Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 3 05 AM BLAKE 05 15 2009 /Medical 4a. Facility dame (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UMATO Caro Date of Birth (Month, Day, If Under 1 Months Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Min Hours 32-9290 1 M 2 F Tenne Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show Examiner must be notified at Yes 2□No Director 10g. Citizen of What Country? 10e. Street and Number Funeral death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 2/200 Baltimore, Maryland 21215-0036 1 TYes Specify 2 3 Widowed 4 □ Divorced I Hygiene. other than "natura rent, the Medical E Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be mollie ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau P.O. BOX 2333 Am Herst 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20 5 Other (Specify) 4 ☐ Donation 21. Signature of uneral price Lice ter the disease, or complications that caused the death. heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 ☐ Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 □ Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 3□ DOA Certification: To 1 ☐ Yes 21 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eutaw 21 N. Ahme

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Poglatrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 20, Physician 2009 Mary V. Bowers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Summit Nursing Home Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 83 West Virginia 217-12-6164 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, if a "dical Evan, not be notified an once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location N/A Baltimore 1X Yes 2 ☐ No MD **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 410 South Vincent Street 21223 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2**X**ÎNo Specify: White Specify Be Completed by 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5 College (1-4or 5+) Meat Packer Food & Beverage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Walls Nannie ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 South Vincent St., Baltimore, MD 21223 19a. Informant's Name/Relationship (Type. Print)
William F. Bowers, Jr. Son 20b. Place of Disposition (Name of Parties place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 5-23-2009 Woodlawn, MD 4 □ Donation (A) □ Other (Specify) Cemetery Signature of Pun 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA **Physician** TWO WEEKS disease or condition resulting in death) /Medical Due to (or as | consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 □ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title pi cortifier

3

State Registrar 3350 WILKENS AVE #307 BACTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

QUAINOO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nd 19a, perFh 9891 5/28/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Belcher 19, 2009 Warren Harding 3:20PM May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1963 Lewis Avenue Rockville I If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 223-24-0720 86 November 8, 1922 Virginia Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
71 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Machinal Examiner may be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1XYes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20851 United States 1963 Lewis Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give WWII Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Mechanic 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be fiill fealth and Mental F Ella Vipperman J. Conner Belcher 19a. Informant's Name/Relationship (Type, Print)
Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 12205 Bayswater Road, Gaithersburg, Maryland 20878 Daughter Dana Elliott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 24 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 New Dublin Cemetery Dublin, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 Markete Das 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non Hodgkins Lymphoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and -tran Due to (or as a consequence of) sician a burial-t Box 68760. Physician/Medical phys: attending p for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 The law requires Prostate Cancer, Diabetes, Coronary Artery Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been si je 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page certificate 1 ☐ Yes 2 X No or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No After this of funeral dire 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medic 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier John M.D D36552 May 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 West Edmonston Road, Suite 401, Rockville, Maryland 20852 Pankaj Talwar, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** VIZY 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore HOSPice/Northwest Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min ND 212-15-5048 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantina must be a series once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐Yes 2 No Funeral Director Raltimore 10g. Citizen of What Country? 10e. Street and Number USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) tuto 12tharade 17. Father's Name (Prst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) eon R. Brooks Minnie ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) GWYNNOAK, MD Z1201 Mother Dr. Minnie L. Brooks 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State -23-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) laugho C. Greene funeral Sis 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final Physician STAGE a END disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 □Yes 2 □No 5 Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√€ No 24a. Was an performed' certificate 1 ☐ Yes 2 🛣 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral din Medical Certification: To 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural
2 Accident 1 □Yes 2 □ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2335 Smith Avenue Svite 203 Baltimore MD 21208 istrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 20, 2009 Physician 9:35 A Norman Lee Bosley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Nottingham 4232 Necker Ave If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Nov. 24, Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Year) **Funeral** Hours Months Days 1 X M 2 □ F 1944 California 213-42-4605 64 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traunctic event, the Medical Experiment must be notified at 1 ☐ Yes 2 🔀 No Director Nottingham Baltimore Md. 10g. Citizen of What Country's 10e. Street and Number 10f. Zip Code 21236 USA 4232 Necker Ave death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Vietnam 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Leville Hygene. Important if item 27 is necked other than "natural", or item any injury or other trainments. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilson Charles William Bosley Martha Louise ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nottingham, Maryland 21236 Mrs. Pamela Ann Bosley/Wife 4232 Necker Ave 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grd. 5/23/09 Timonium, Maryland Maryland 21204 Inc. 1050 York Road 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Towson, Ruck Towson Funeral Home, 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death MONTHS GLIOBLASTOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and ned for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month in the past 12 months? Day signed by the a □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 □ Yes Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 XNo 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

MO CRNP

29b. Signature and title of certifier

30. Name and address of person

1550 ORLEANS ST, CRBIL, SUITE IM-16, BACTO, MD 21231 RRIGNO

ho completed cause of death (Item 23a) (Type, Print)

29c. License number

R097025

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State of Maryland / Dep   - State Registrar C6	artificate of Death		eg. No.	16506
			1. Decedent's Name (First, Middle, Last)		0.01. (0		3. Time of Death
	Physicia /Medic	al	Gloria Ball Beckwith		May	19 2009	7:00 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Towson		4c. County of Death	
	Funeral		Edenwald  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign intry)
	Director		219-28-5570 1□M 2対F 78 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, November	7, 1930 Mar	yland
	and	ŀ	Usual Residence of Decedent         10c. City, Town or L           10a, State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits
	the Marylar 28a-f show	to	Maryland Baltimore Towson				1 ∐Yes 2 🕱 No
	th with the Maryla 23a or 28a-f shov	Direc	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Cou	intry?
	ath wil	Funeral Director	200 Southerly Road, Apt. 1201	21286		U.S.A.	ttdiam
	items	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modical Exp. instruments by multified at	by	3 🗓 Widowed 4 □ Divorced Year or Dates:	1 ☐Yes 2 ☑ No Specify:		Specify: Wh	ite
2-0	72 ho	Be Completed by	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work		16b. Kind of Business/I	ndustry
121	I within 72 ho giene. r than "natu Ins Medical	mp	Flementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)  ical Education Tea	cher	Educati	on
d 2	e filed val Hygie other t	ပ္တို	17. Father's Name (First, Middle, Last)	18. Mother's Nam			
an	ild be fental rked o	To B	John Horace Ball	Etta	Louise	Dickerson	
ary	2 should be filed or and Mental Hygin and Mental Hygin is marked other raumatic event, II		, , ,	ling Address (Street and Number or Rui			ip Code)
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Jore	Pages 1 nent of H int: if ite iry or ot		1 XI Burial 2 □ Cremation 3 □ Removal from State   Dollar manage	ematory or other place)		Baltimore,	
Baltimore,	a fig		4 Bonaton o Bono (opposity)				
Ba	permit. Departn Importa any inju			Ruck Towson Funera	1 Home,	Rd., Towso Inc.	11, MD 21204
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	nomal		-	Onset and Death
Ч	/Medical Examiner		resulting in death)  Due to (or as, consequence of):	Do King	24 1	ANYONO	11)400
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68760,	icate l physic	edical	d				
Box (	eath certii attending for use a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	ivery
	death	sicia	in the past 12 months?  1   Yes 2   No	Control of the contro	~	Month	Day Year
P.0	that the dened by the a	Physician/M	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	undarlying cause given in Part I	23e Did to	bacco use contribute to	the cause of death?
ds,	signed d be det	þ	Part II. Other significant conditions contributing to death out not resulting in the	underlying cause given in rait i.		es 2 No 3 Pi	200
Vital Records,	w requires to been signer should be considered.	Completed			24a. Was a	ın 24b. Were au	utopsy findings available
Re	: The law cate has page 2:	dwo			autops perfori 1 □ Yes	med? death?	completion of cause of : 2 □ No
ital	ician: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?		th (Check only on		
	Physic this ce al dire	မ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			ence 6 Other (Spe	cify)
n C	ding Physician: h. After this certific funeral director,	ion:	27. Mann   Death   28a. Date of Injury (Month, Day, Year)   28b. Time Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28a. Describe n	ow injury occurred	
Division of	Attendir death.	fical	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		28f. Location (S	treet and Number or Ri	ural Route Number,
Ξ	s after al Direction	Certification:	4 ☐ Homicide determined building, etc. '(Specify)		City or Tow	n, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (	29a. Certifier (Check ov) Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the our erred at the time, o	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
	o the ithin 2 o the omple	Med	and manner stated.  29b. Signature and title of ce tifier	29c. License number	2	29d. Date sign <b>y</b> â (Mont	hyDay, Year)
	F > F 0		physi	an 1 29	769	5/191	09
	4		30. Name and address of person who completed cause of death (Item 23a) (Typ	a, Print)	6/0	1, 1	2/1228
	8		31. Date filed (Month, Day, Year) 32 Registrar's Signature	5 160 Rd ha	12/1/	all a	<u> </u>
	Sta Registi		MAY 2 2 2009	are			

DHMH 17 Rev 1/2001

09-03578 Wendy Baer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

endy	Baer		1- Fo	or State	Sta	ate of	Maryla	nd / De	partr Certifi	ment of icate of	Health Death	and	Menta	н Нуд		Reg. N	0	20	09	1650
	Physicia	1	Regi	strar ecedent's Name	(First, Middle	e,Last)			207 (117)					1	Date of De Month	ath Day			3. Time of De	
edia	el Examii	ner			WENDY	1	and and no	mhas)		BAE	b. City, Tow	n, or Lo	cation of		May 4, 2		4c. County	of Death	00141110	
1				Facility Name (if a 3710 Pikesw			reet and nu	mber)			Randalls						Baltimo			
	Funeral		5. S	ocial Security Nu	mber	6. Sex		7. Age (In y	rs. last i	birthday)	If Under 1	Year Days	If Under Hours	24Hrs. Min.				Foreig	hplace (State	or
	Director		21	9-70-56	0	1M	2 X F		47	Yrs	Monard	0.00			02/1	.0/.	1962	Col	untry) MD	
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0	nd show a	٦		MD	BAL	TIMO	RE			RAN	DALLS		l				Citizen of V	VI -4 C2.11	1 Yes	2 A No
1	ne Maryland or 28a-f show any fied at once.	recto	10e	. Street and Num							10f. Zip Co						JSA	vnat Cour	iu y :	
1	ath with the Maryland tems 23a or 28a-f sho st be notified at once.	Funeral Director	11	3710 PI	KESWO			cedent Ever	in U.S.	13. Wa	211 s Decedent	of Hisp	anic Ongi	n? (Spe	cify Yes or	1	14. Ra		can Indian, Bl	ack,
	leath w	uner		X Never Marrie	d 2 M		Armed F			lf Y	es, specify (	Cuban,	Mexican,	Puerto R	ican, etc.)			nite, etc. /: WH	TTC	ļ
	after d	by F		Widowed			Yes, Give Ye	ar		16a. Deceder	Yes 2 X			ind of wo	rk done	16	Specify b. Kind of			
	2 hours "natu	ted	15	5. Decedent's Ed Elementary/Seco				1-4 or 5+)	11	during m	ost of working	ng life. I	DO NOT	use retire	d)					
036	ed within 7. Tygiene. other than	ompleted				ŀ	5	j+		N	URSE	1.		Name of	First, Middl	a Mai		SING		
5-0	ld be filed within 7. fental Hygiene. narked other than event, the Medical	CO e CO	17.	Father's Name (	First, Middle	, Last)			BAEF	R		1		s Name ( ROSAL		e, Mai	gen Sumai		CHWARTZ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner.	To B	198	a. Informant's Na		ship (Typ	e, Print )		DALI	19b. Mailin			and Num	ber or Ri	ural Route I				e, Zip Code)	,
Z	d 2 sho Ith and n 27 is			RICHARD		/ BF	ROTHER	₹	OOK DI	ONE ace of Dispo	LONG			OUR	Date	VGSV	VILLE Oc. Location	n - City o	21087 r Town, State	
	es I an of Hea If iten		20:	a. Method of Disp Burial 2	osition X Crematio	n 3	Removal	from State	CARI	ematory or o	ner place) RFMAT	ION	INC	05/2					AD, MD	Ì
Raltimore	it. Pag rtment rtant: y or of		4	Donation 5	Other S	pecify:	1		071111		Name and A					- 1	VINSO	N & I	BROS.,	INC.
a	Depa finip		1 7	MAN	W/	9	1111	ger	,	8	900 RI	EIST	ERST	OWN	ROAD	<u>- F</u>	IKES	VILLE	, MD	21208 ate Interval
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	e be executed ysician and burial - transit	edical	-	X UNPENDED		<u>-</u> ا	AMENDE	23a,	27,	28a-f	perME	, g	892	5/4/	09 TT					
G	ate be e	Medi	IF	FEMALE:			23c. If ye	s, outcome o	of pregna								23d. Dat	te of delive	ery Day	Year
703	OX OO O	lan/	231	b. Was decedent past 12 month	pregnant in s?	the		e birth egnant at time	e of dea		etal death Other (Spec	3 cify)	Ectop	c pregna	incy		Mon	uı	Day	100.
03203	<b>BOX</b> The death the attervel the attervel or t		1	Yes 2			L-mark	known							730 1	Did toh	acco use o	ontribute	to the cause o	of death?
	that the detached			art II. Other sign	ificant cond	ditions	contributing	g to death bu	ut not re	sulting in the	underlying	cause	given in P	ari i.	_	Yes			robably 4	
-	Division of VITal Kecords, F.O. ral or Attending Physician: The law requires that it is after death.  The alber death.  The short sher this certificate has been signed by led; in the the fineral director mass 2 should be detailed.	pate														Was a		4b. Were	autopsy findir	ngs available of cause of
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	OF VIES ing Physicis After this co	To Be	<u>-</u> ا د	examiner?	2 No	Н	ospital: 1	Inpatient		ER/Outpatie		OOA	Other <sub>4</sub>		ng Home		Residence ow injury o		her: Scene	
٠	not ding P h. After	5	5 2	7. Manner of Dea		ending	(M	ate of Injury onth, Day,Year	)			1	Yes 2X		unk					
	'ISIO ' Atten er deat irector	ing m		2 Accident 3 Suicide		vestigation	28e F	5/5/09 Place of Injury	y - At ho	Fd 12 ome, farm, s	reet, factory		building,	etc.	28f. Loca	tion (S	treet and Nate 37	umber or	Rural Route I	Number, City
i	Div pital or ours aft eral Di	illed i		4 Homicide	de	etermine	(Spec	:пу)		lence					Ranc	lal.	LSTOW	n, ML		
D	Division of Vital Records, P.O. Box 607 of the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy commodate filled in his the fineral mase 2 should be detached for use as the b	pietery		9a. Certifier 1 Check only 1	Certifying  Medical E	Physici xarniner	an: To the :On the ba	best of my k	nowledg	ge, death oo nd/or invest	curred at the gation, in m	e time, o y opinio	date and p on, death o	olace, an occurred	at the time,	e cause , date a	e(s) and mand place,	and due to	o the cause(s)	
V	To t		Medical	29b. Signature an			and mann	er stated.					se numbe	_			29d. Date	e signed (	Month, Day, Y	
				The.	don	M.	Kin	Q TI	n.	un	), L	0.0	.M.E.	0019	-		May 4,	2009		
			3	30. Name and ad Theodore				cause of dea istant Me			111 P	enn S	treet, E	altimo	re, MD 2	21201	l			
		Sta	te 3	31. Date filed (Mo				Registrar's		uro A	Ked									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 18 Day Year Month Campbell, Jr 2153 **Physician** obert May 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 □ F 247-58-7851 70 12-31-1938 N.C **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Y Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 21213 U S 2818 E. Federal Street Α Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1

Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Potts and Callahan College (1-4 or 5+) Elementary/Secondary (0-12) <u>12th grade</u> N/A Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert W. Campbell, Sr Zeal Hood မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21213 Vanessa Lewis-Sister 2605 E. Hoffman Street 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Bethel Cemetery 5-25-2009 Waxhaw, N.C. 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter that disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or cheart failure. List only one cause on each line. 1101 E. North Avenue Balto, MD 21202 Approximate Onset and Death Immediate Cause (Final Cardiovascular Disease y Car A theroscle rotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if a.y, leading to firm dictionable. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 2 🗌 No P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes certificate has been sig lirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 2 40 Yes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examinar? 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 2 ER/Outpatient 3 DOA ပ 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Ai completely filled in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

The 31. Date filed (Month, Day, Year) State Registrar MAY 2 2 2009

Hospital Hopkins 32 Registrar's Signature

Ductor

Kin Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

back

Res-000

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Anthony		1- For State	State	e of Maryl		epartmen Certificate			and	Menta	i Hyg		Reg. No.	2	nno	)	1650
Physici Medičal Exami	an/	Registrar 1. Decedent's Nam	e (First, Middle,L		ael	Anthon	v	Chas	36			Date of De Month May 17,	eath	Year		Time of 0709 i	
		4a. Facility Name (	if not institution, g	ive street and n		AIICIIOII	4	b. City, Tow Baltimo	n, or Lo	ocation of				c. County of	Death		
Funeral		5. Social Security I		Sex	7. Age (In	yrs. last birthda	y)	If Under 1		If Under	24Hrs.	8. Date of E	Birth(MM	(DD/YYYY)	9. Birthpla	ace (Sta	te or
Director		216-84	-6083 1	<b>X</b> M 2 F	4	7	Yrs.	Months	Days	Hours	Min.	10-	31-	1961	Foreign Country	y)	MD
япу		Usual Residence of	f Decedent 10b. County		110c	. City, Town or	ocatio	on							100	d. Inside	e City Limits
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farylar 28a-f s	Director	10e. Street and Nu						10f. Zip Co	de				10g. Ci	tizen of Wha	at Country	?	
vith the Maryland s 23a or 28a-f show a notified at once.	۱		. Benta	lou St	reet			2	121	6					A		
ath wit	neral	11. Marital Status  1 X Never Marr	ied 2 Marri	12. Was De	Forces?		3. Was	Decedent es, specify (	of Hispa Juban, I	anic Origir Mexican, F	n? (Spec Puerto R	cify Yes or I ican, etc.)	No-	14. Race - White	- American , etc.	Indian,	ыаск,
ifter de I'', or i	y Fun	3 Widowed		1 Yes	2 <b>X X</b> aar	No	1	Yes 2X	ς <sub>No</sub>	specify:				Specify:	Blac	ck_	
hours a natura xamit	ed by	15. Decedent's E						s Usual Oc					16b.	Kind of Bus	siness/Indu	istry	
36 hin 72 e. thau "	Completed	Elementary/Sec	ondary (0-12) grade	College	(1-4 or 5+) N/A		D	isab]	led					Disa	abled	3	
5-0036 led within 7 Tygiene. other than		17. Father's Name	(First, Middle, La		,				18					n Surname)			
2121 Muld be fi Mental I marked c event,	Be c	19a. Informant's N	niel Ga			19h M	Aailing	Address	-					Chas		p Code	
nore, MD 21215-0036 gest 1 and 2 should be filed within 72 hours af not 4 thealth and Mental Hygiene.  It: If item 27 is marked other than "natural other transmatic event, the Medical Examin	ပ္		lle Dut		ther	F											
re, r I and FHealth Fitem er tran		20a. Method of Dis	sposition			20b. Place of D			of ceme	etery,		Date	200	. Location -	City or To	wn, Stat	e
Baltimore, bermit. Pages I ar Department of Hee Important: If ite		4 Donation 5	Other Spec	ify:	mom otate	King						2-09		anda]		own	, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiers (Department of Heath and Mental Hygiers), or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmatic event, the Medical Examiner must be notified at once.	l l	21. Signature of F	uneral Service Lic	censee		2		ame and Ad						st F, Balt		M D	21202
Physician		23a. Part I. Enter t			caused the	death. Do not e	nter th	ne mode of	lying, s	uch as ca	rdiac or	respiratory	arrest, s	hock, or hea	art /	Approxi	mate Interval
/Medical xaminer	2 Y	Immediate Cause		a. Complicat	tions of G	Sunshot Wo	und										Death
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ž: g. //.	Examiner	(Disease or injury events resulting in	that initiated	Due to (or as	a conseque	ence of):								<u></u>			
be executed ician and urial - transi	dical E	UNPENDE	<u> </u>	dAMENDED	)												
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x 68 th certif	iciar	past 12 month	ns?	4 Pre	e birth gnant at tim	e of death 5		tal death her (Specif		LCtopic	pregnar		le.	WOTE	ou,		100.
. Box the death of y the attention the death of the attention the attention the attention uses the second that	Physician/Me	1 Yes 2 Part II. Other sign		3 0116	nown	it not resulting i	the i	inderlyina c	ause di	ven in Par	rt I.	23e. Di	d tobacc	o use contr	ibute to the	e cause	of death?
P.O.	δ	rait ii. Other sigi	incant condition	is continuuting	to death bu	A Hot resulting i	1 (110 (	andenying o	ause gr	veri ii i i a				_		_	Unknown
rds, require been si	Completed	i .		-								24a. W	as an utopsy				ngs available of cause of
(eco The law ate has	l mo											pe	erformed		death?		2 No
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	ţi ţi	1 Natural	5 Pendin	9   -	oth, Day Year) 0, 1988	2215 1	ırs		1 Y	es 2 🗸	No S	Subject s	shot				
Division of V spital or Attending Ph hours after death. meral Director: After t y filled in by the funeral	Certification:	2 Accident 3 Suicide	Investig	not be 28e. Pl	ace of Injury	y - At home, farr	n, stre	et, factory, o	ffice bu	uilding, etc	- 1	or Tow	n, State			Route	Number, City
ospital hours uneral y fillec		4  Homicide	determ Certifying Phy	(0,000	y) Alley			arod at the ti	mo do	to and nia				et, Baltimo			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Charle ante	Medical Exami	ner:On the basi and manne	s of examin	nowledge, death ation and/or inv	estiga	tion, in my o	pinion,	death occ	curred at	the time, d	late and	place, and	due to the	cause(s	)
To Tio	Me	29b. Signature an	d title of certifier	/	Stateu.			i i		number				d. Date sigr		h, Day, Y	'ear)
		Ca	ral	Hell	la	~			O.C.N	Л.E.			M	ay 21, 20	009		
2		30. Name and add		ho completed ca stant Medica			enn	Street, B	altimo	ore, MD	21201	1					
		31. Date filed (Mo			Registrar's												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Harrison Cornforth Carlson May 19 2009 8:55p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Fairhaven Sykesville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthdav 6. Sex **Funeral** Months Days Hours 1 M 2 □ F 221-07-6943 95 Director 29 1913 MA Aug Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ral", or items 23a or 28a-f show Examiner must be notified at MD Carrol1 Sykesville 1 TYes 2 □ No Funeral Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hyglene. Important: I flem 27 Is marked other than "natural", or items 23a or any inlury or other traumatic event, Its Modoal Expinity inner but naise the property. USA 7200 Third Avenue 21784 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. white Completed by 3 ☐ Widowed 4 ☐ Vivorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) iled w..
if Hygiene.
id other thar
c event, thy Dupont Corporation Elementary/Secondary (0-12) College (1-4or 5+) chemical engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Elizabeth Cornforth Harry John Carlson မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ron Comfort (personal rep.) 24 N. Court St., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-21-09 All County Cremation Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses MOO764 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner obst hronic Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes prostate cancer 1 ☐Yes 2 ☐No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

20

DHMH 17 Rev 1/2001

MAY 2 2 2009

29b. Signature and title of Certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Tan Mi) 1645 Liberty William Tan MD 32. Registrar's Signatur

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 20

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009

			1 - State Registrar			Cer	tificate of I	Death		R	eg. No.	2009	16.	)
1	Plus de la		1. Decedent's Name (First, Middle,	Last)					2.	. Date of Deat Month		Year	3. Time of	Death
	Physici /Medic		Clara I.	Cain					N	1ay		2009	8:57	Ам
>	Examir		4a. Facility Name (If not institution,	-			4b. City, Town, or		Death			County of Death		
8.			Genesis-Fran				Rose					Baltim	ore	ø
	Funeral Director		216-14-7344	6. Sex 7. Age 1 M 2 X F	e (In yrs. last bir 87	rthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day, July,	Year)	Cou	place (State of ntry) Ltimor	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Loc	ation						10d. Inside Cit	tv Limits
	farylarylarylarylarylarylarylarylarylaryl	5		ltimore		ry H							1 □Yes	
	the A	ect	10e. Street and Number	CIMOLE		LLYIL	10f. Zip Code			1	Oa Citiz	en of What Cou		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 23a-f show ant, the Medical Examinar must be notified at	Funeral Director	8730 Gerst A				2112	28				USA		
	er de	une	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origir an, Mexican, I	n? (Specif Puerto Ric	y Yes or No- can, etc.)	1.	<ol> <li>Race - Ameri Black, White,</li> </ol>		
9036	ours after ral", or i	þ	1 ☐ Never Married 2 ※ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 N If Yes, Give Year or Dates:	10	1	□Yes 2 <b>X</b> INo	Specify:				Specify: W	hite	
2	72 h "natu dicai	ete	15. Decedent's (Specify only highest	s Education : grade completed)	16a.	. Decede (Give k	ent's Usual Occup aind of work done of ONOT use retired	ation during most o	of working		16b. Kin	d of Business/Ir	idustry	
2121	d within giene. er than ' the Me	Completed	Elementary/Secondary (0-12) 1 2	College (1-4or 5-	+)		maker	n) -			At	Home		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.	To Be (	17. Father's Name (First, Middle, L Charles Trac	. ,						irst, Middle, I h Frie		Gurname)		
ar)	2 sho and l is ma auma	•	19a. Informant's Name/Relationshi				Address (Street a							
≥,	and ealth m 27		Norton Cain/	Husband			Serst Av							
Baltimore,	Pages 1 ment of H ant: If ite ury or otl		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.		Park W	f Dispos ry, crem COCC C	ition (Name of latory or other place emetery	o (0	5/23	8/09		ation - City or T kville		
Balt	permit. Depart Import any Inj once.		21. Signature of Funeral Service L	icensee AMA	M	EXA 880	Name and Address ns line: 0 Harfo:	ral Rd	hape • Pa	l & C	emat e. M	ion Se	rvice:	s
	- 1		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused	the death. Do	not ente	r the mode of dyin	g, such as ca	ardiac or r	espiratory arr	est,	2 2123	Approximate Interval Bety	e ween
9	Physician		Imm riate Cause (Final				CAN					J DR	Onset and D	Death
	/Medical		resulting in death)		a consequence							,	1 ( 1 4 1	-
- A	Examiner		Sequentially list conditions,	b										
-	p #	iner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	i eonsequence	of).						.83		
H	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	с										
68760,	ertificate be executed ling physician and e as the burial-transit	cal E	youthing in double, Eddi	d.	a consequence	01):								
	rtifica ng ph as th	Medical	VE PERMIT											
O. Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ 110 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 4 4 □ Pregnant at 9 □ Unknown	2 ∐Fetal death		Ectopic pregnancy Other (specify)	,			23	3d. Date of deliv Month	-	/ear
J	that ned by deta		Part II. Other significant condition					en in Part I.		23e. Did tol	acco us	e contribute to t	he cause of d	eath?
SD	quires n sign	d by	DEMENT	IA DE	PRES	51	ON		[]	1 □ Ye	es 2	] No 3 ☐ Pro	bably 4	Inknown
Vital Records,	sician: The law red certificate has bee irector, page 2 shou	Completed					·		_	24a. Was a autops perforr	y	24b. Were auto prior to co death?	opsy findings a impletion of ca	available ause of
g		င္ပ	25. Was case referred to medical							1□ Yes	2 12 No	1 ☐ Yes	2□ No	
>	yslcian: iis certific director,	O B	examiner?	Hospital: 1 1 Inpatier	nt 2□ER/Ou	tnationt	3□ DOA Othe	DF:		Check only on		□a (a		
on or	ding Pr	$\vdash$	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. 1	Time of njury	28c. Injury Work	4 H Nurs	280	5 ☐ Reside		Other (Speci	<u>(y)</u>	
DIVISION	al or Attendi after death. I Director: A d in by the fu	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e Place of initi		rm, stre				Location (St City or Town	reet and n, State)	Number or Run	al Route Num	ber,
5	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C		Physician: To the best of xaminer: On the basis of and manner stal	examination an									.)
	To the vithing To the comp	Me	29b. Signature and title of certifier	ishalo 1	40		29c. License	e number 4 0 0 0	Z			signed (Month,		
,	;		30. Name and address of person w	ho completed cause of de	eath (Item 23a) (							ORE,		
2	Sta	te	JIM PARSHAZ 31. Date filed (Month, Day, Year)	32. Registra	FRANK r's Signature			AIVE	UK	, BAL	-111	KORE,	, (3)	
	Registr	ar	MAY 2 2 2009	Person.	A ha	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tems 20b. c. per fh 8891 5-22-09 yt 30 State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MA 2009 /Medical 4b City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner Medica enter ALTIMORE Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex . Age (In vrs. last birthday Social Security Number **Funeral** Months Hours 1 ☐ M 2 ☐ F Director 218-16-2347 Oct 28, 1925 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☐ No Director Maryland n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with o e items 23a c 2418 Franklin Street 21217 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ò 1943 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced Black Year or Dates "natural", 1950 Completed Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4or 5+) T. Dashew Truck Driver 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental William Carey Bertina Parker 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health an Important: If Item 27 is any injury or other trau once. 130 West Hamburg Street Baltimore, Maryland 21239 Denise Carroll Crownsville Veterans Cem. Mt. Calvan 20b. Place of Disposition (Name of 20c. Location - City or Town, State **Crownsville** Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/22/09 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a currequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a cun equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or de a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician s the burial Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes signed by the a 2 □ No 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed res 2 No certificate has 1 Yes 25. Was case referred to medical exampler? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Many er of Death 1 ✓ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No ours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Fo the 29b. Signature and title of certifier 29c. License number B17453 29d. Date signed (Month, Day, Year) DEA #AUY176435B17 MBrown Mysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREEN Street BALTIMOLE, MD 21201 Jennifer N. Brown Registrar's Signature 31. Date filed (Month, Day, Year) 32 State MAY 2 2 200 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year WAY! **Physician** FIMA 200 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMOPE HARBOR HOSPITA N/A 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. | Date of Birth (Month, Day, Year) 10/29/1925 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days 1 □ M 2 🖰 F 83 229 24 9616 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10h. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 1 ☐ Yes 2 No Pasadena Director Anne Arundel Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 U.S.A. Funeral 7944 Tick Neck Road 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. þ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie Williams B.F. Bailey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, Maryland 21122 Richard Czajkowski / Son 7944 Tick Neck Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 05/21/2009 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Lic 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the geath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5 DAYS Physician SHOCK /Medical Due to (or as a consequence of): **Examiner** 5 DAYS PNEUMON(A MRSA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Crus to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ ICERTY ES PEPTIC THUROIDISM 2∏ No 3 Probably FAILURE Completed Be Medical Certification: To

Division of Vital Records, P.O. Box 68760,

ATRIAL			BETES			opsy prior to completion of cause of death?			
25. Was case referre examiner? 1 ☐ Yes 2 ☑ €	ed to medical	Hospital:		26. Place of Dea	ath (Check only				
27. Mapmer of Death 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investigation 6 ☐ Could not b	(Month, Day, Year)	M 1[	rkí? ∐Yes 2∐No		e how injury occurred  (Street and Number or Rural Route Number,			
4 ☐ Homicide	determined	building, etc. (Specify)			City or T	own, State)			
29b. Signature and t	tle of certifier	-65	29c. Licer	se number		29d. Date signed (Month, Day, Year)			

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BALTIMORE

MD

2009

21225

State Registrar DENNIS

31. Date filed (Month, I

MD 3001 5 Registrar's Signature

HOUSESTAFT

address of person who completed cause of death (Item 23a) (Type, Print)

FRMULD

HANOVER ST.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		State of Ma	aryiano		rtificate o			entainy	Reg. No	Z 11 E	19	1651	4
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2	Physicia /Medic		101	767	Kegi	$\Omega$	<u> </u>	ENHI	RU		May	20	2009		9:53 P	-
15	Examin	er			e street and number)			4b. City, Towr		on of Death		4c.	. County of [	Jeath		
tis			3900 Pine 5. Social Security Nu			e (In vrs. la	ast birthday)	Baltin If Under 1 Ye	ar   If Un		8. Date of Bi (Month, D	irth ,	9.	Birthpla	ace (State or Foreig	
2	Funeral Director		220-52-28 Usual Residence of	305 <sup>1</sup>	□м 2🔀 F	60	Yrs.	Months Da	ys Hou	rs Min.	3/17/1			Countr aryl		
16	yland now	Ì	10a. State	10b. County		10c. City	, Town or Lo	cation						100	d. Inside City Limit	
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114	with the Maryland sa or 28a-f show	Director	10e. Street and Nun	nber				10f. Zip Cod					tizen of Wha	t Countr	ry?	
01	death w ms 23a	ral	3900 Pine	ewood Ave			3 40	21216		Origina (Co.	noify Von or N		.S.A.	America	an Indian	
<i>C</i> -0036	s 1 and 2 should be filed within 72 hours after death with the Mafylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It's Medical Examinar Instal Larrolling at	by Funeral	11. Marital Status 1 ☐ Never Marrid 3 🖫 Widowed		12. Was Decedent I Armed Forces? 1 ∐Yes 2 XN If Yes, Give Year or Dates:			Was Decedent If Yes, specify C 1 □Yes 2⊠I			Rican, etc.)		Black, \ Specify:	White, et	te te	
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70	Hygie Hygie ther t		17. Father's Name (	First, Middle, Last,			Car	TORCE	18. M	lother's Name	(First, Middl					
and	d be ental ked o	To Be	Hubert	Sturm					Ма	ry Da	vis					
DEA Maryland	2 should be filed vand Mental Hyginis marked other aumatic event, II.	F	19a. Informant's Na	me/Relationship (	Type. Print)			ng Address (Str								
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Imore imore	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra				Removal from State		atany G	osition (Name o matory or other ifts Regi	stry	5/22	)/2009	Han	ocation - Cit	Mar	yland	
Balt	permit. Departi Importi any inj		21. Signature of Fu	SCOTT			7	2. Name and Ad 522 Con	nelle	y Dr.,	Ste. F	, На				
1/2	Physician /Medical Examiner		23a. Part 1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death)	Final	plications that caused one cause on each li a.  Due to (or as	sta	tic	ter the mode of	dying, suc	h as cardiac	or respiratory	arrest,		-	Approximate Interval Between Onset and Death	
68760,		edical Examiner	Sequentially list coi if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	nditions, mediate rlying injury .ast	b. Due to (or as				-							
P.O. Box 68	eath certi attending for use a	Physician/Medi	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 20 9 □ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3	☐ Ectopic pregi		_		-	23d. Date of Month		ery Day Year	
ds, P	w requires that the dispersion been signed by the should be detached	d by PI	Part II. Other signif	icant conditions	contributing to death b	out not resi	ulting in the	underlying cause	e given in F	Part I.					ne cause of death? pably 4 ☐ Unkno	
Division of Vital Records,	The law requate has been page 2 shou	Completed by						<del></del>			24a. Wa au pe 1 □Yes	topsy rformed?	pri de	ere autor or to cor ath? ]Yes	psy findings availal mpletion of cause o 2  No	ole of
/ita	ician: The certificate ector, pag	Be (	25. Was case refer examiner?	red to medical						Place of Deat	h (Check onl	y one)				
n of \	ding Physician: h, After this certific funeral director, I	မ	1 ☐ Yes 2 🔀 27. Manner of Deat 1 🕱 Natural	h 5 Pending	28a. Date of Inju		ER/Outpation 28b. Time Injury	of 28c.	Other: 4 [ Injury at Work? 1 □ Yes	<u>-</u>	ome 5 ARe 28d. Describ				ý)	
Divisio	To the Hospital or Attendl within 24 hours after death, To the Funeral Director; A completely filled in by the fu	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigatio 6 □ Could not b determined	e 290 Place of In	jury - At he tc. <i>(Speci</i> i	ome, farm, s fy)	treet, factory, of			28f. Location City or 7	o (Street a Town, Sta	and Number ate)	or Rura	al Route Number,	
	e Hospita 24 hours e Funeral letely fille	Medical C	29a. Certifier (Check only one)	1 Certifying P	hysician: To the best miner: On the basis of and manner st	of examina	owledge, dea ation and/or	th occurred at tinvestigation, in	he time, da my opinior	ate and place n, death occu	, and due to t rred at the tim	he cause ne, date a	e(s) and man	ner as s	stated. the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and	title of certifier	relactiv	w		29c. Li	cense num	ther 46		29d. D	Date signed	Month,	Day, Year) ZOO9	
			30. Name and add	ress of person who	completed cause of	death (Iter	n 23a) (Type	Print)	Blue	0, 7	Seltin	MOrc	2, ME	2	2009	
	Sta Regist		31. Date filed (Mor	th, Day, Year)	32. Aegist	rar's Signa	ature	arkel								

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Di Xon 17 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) NA BALTIMORE RICHEY HOSPICE JOSEPH 9. Birthplace (State or Foreign Country) S. CAROLINA If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1 M 2 □ F 91 248-20-6981 FEBRUARY 6,1918 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No BALTIMORE MARYLAND 10g. Citizen of What Country? 10e. Street and Number BROOKFIELD 2512 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: /2 Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RAILROAD 18. Mother's Name (First, Middle, Maiden Surname) アルーレムKNCいい 17. Father's Name (First, Middle, Last) DIXON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2512 BROOKFIELD AVE., BALTIMURE,MD 21211 (WIFE) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY CS/21/2009 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H. BROWN JR. FUNERAL HEME 2140 N. FULTON AVE, BALTIMORE, MD 21-217 ellamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) state e Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Atthina 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

/Medical Examiner attending physician for use as the buria been signed by the should be detached cate has page 2 s certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifics completely filled in by the funeral director, f

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

show

28a-f

ò

23a

or items

"natural"

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other tha any Injury or other traumatic event, If a

**Physician** 

Baltimore, Maryland 21215-0036

event, the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown ≥ Completed 25. Was case referred to medica examiner? Be 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 2 Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

90.	Signature	and	title	or c	ertiti	er		
	•				h	u	ib	2

31. Date filed (Month, Day, Year)

1100 64267

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

MAY 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle, Last) **Physician** /Medical ity Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner VillA Atons V: 11e deric Nursing yrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Sountry) Days Min. 1**X**M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County d other than "natural", or Items 23a or 28a-f show event, the Wedical Examiner must be nutfilled at tons Ville 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Co. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White etg 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ₩Widowed 4 □ Divorced Cive kind of work done during most of working Up DO NOT use retired) Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mental ODGe. Elementary/Secondary (0-12) College (1-4or 5+) Ain tenance 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Las Be 0 daughter it's Name/Relationship (Type 20b. Place of Disposition (Name of Method of Disposition NA fiche 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Si a ture o Funeral Service Lisensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, ock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, from John Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the tuneral director, page 2 should be detached for use as the temperal director, page 2. 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Chron 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Records, Division of Vital

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 0

32 Registrar's Signature

29c. License number

05030

29d. Date signed (Month, Day, Year)

MD 21228 - Rodollo Fernandy MD

### 1. Decedent's Name (First, Middle, Last) Physician DNA /Medical 4a. Facility Name (If not institution, give street and number) Examiner Social Security Number **Funeral** 1 ☐ M 2 € F Director 217-38-8996 Usual Residence of Decedent with the Maryland 10a. State 10b. County show other traumatic event, it a Modical Examiner must be notified at Director Baltimore Maryland 28a-f 10e. Street and Number ŏ or items 23a 1121 St. Agnes Lane death v Funeral 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or itee 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Be Edward Williams ည 19a. Informant's Name/Relationship (Type. Print) Christine Carrington 20a. Method of Disposition Department of H Important: If Ite any Injury or of 1 ★Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ending physician and use as the burial-transit P.O. Box 68760, Physician/Medical attending IF FEMALE: for

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Year 3:20 a May 16, 2009 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Baltimore Ridgeway Manor Nursing Center If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday, Date of Birth (Month, Day, 9. Birthplace (State or Foreign Year) Days Hours Min Months Sep 27, 1936 Maryland 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 □ No **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 21207 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No Specify Specify: Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) **Baltimore County Comm.** Clerical 18. Mother's Name (First, Middle, Maiden Surname) Louise Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3121 Gwynn Falls Parkway Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 05/21/09 Baltimore, Maryland Arbutus Memorial Park 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as an insequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 🕠 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 1 Marsing Home 5 | Residence 6 | Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ye Rd. Caforsville.

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical Be examiner? 1 Yes 2 LNO ၉ Certification: 27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only 2 Medical Examiner: 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

detached the

signed by the

After this certificate has been

To the Hospina. .. within 24 hours after death.

To the Funeral Director: Aft

Ammoletely filled in by the fur

page 2:

funeral

The law requires that

or Attending Physician:

Division of Vital Records,

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

1009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ECINA ZO , 2009 MAL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHAPEL imon un BAUTIMORE 8. Date of Birth (Month, Day, Sept 6, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Mary land 1 □ M 2 □ V Director 220-09-8480 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10h Counts 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglen.

That I flem 27 Is marked other than "natural", or liems 23a or 28a-f shown mit: I flem 27 is marked other than "natural", or liems 23a or 28a-f shown ury or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ YNo MD Baltimore Director Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 74 Tudor Court 21093 U.S.A. Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify If Yes, Give Year or Dates: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rachuba Lawrence Frances Baranowski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence P. Dorbert-son 1511 Regent Dr., Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I-Important: If Ite any Injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 5/27/09 Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 8 MONTHS EREGROVATEUM disease or condition resulting in death) /Medical Examiner THEROSCLERUSIS Sequentially list conditions, if any, leading to influente cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 Yes 2 1 No 1 ☐ Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 within 24 hours after death.

To the Funeral Director: After this 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 31. Date filed (Mor#h, Day)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THATON

29b. Signature and title of certifier



Timonium,

MANYEMIN

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Timonium Mays Chapel If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Nov. 3, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Illinois Days 1 □ M 2 🔀 F 94 Nov. 1914 557-16-1669 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 28a-f show of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Timonium **Funeral Director** Baltimore Md. death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA Roundwood Rd. 12261 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No altimore, Maryland 21215-0036 Specify. Specify. White Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Transportation Office Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Zimmerman Stoek1 <sub>P</sub> Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) York, Pa. 17403 994 Stream View Lane Mr. John O'Neill/ Per. Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of He Important: If iten any Injury or oth once. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-23-09 Timonium, Md. Dulaney Valley Mem. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause un each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to for his a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 200 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 200 2 ER/Outpatient 3 DOA Other (Specify) 1 ☐ Yes Certification: To 27. Manner of Death 1 A latural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Eertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

IJ

30. Name and address of person w

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

o completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:40 A M Agnes Marie Davis May 18, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Timonium** Towson Stella Maris (Cardinal Shehan Center) Birthplace (State or Foreign Country) If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min Months Days 1 □ M 2 X F VA 82 Feb 23, 1927 Director 219-22-4355 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, it a Modical Examiner must be notified at 1 ☐ Yes 2 🛛 No Director Elkridge MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21075 U.S.A. 5968 Montgomery Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Dept. of Assesments 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Lucille Hattershelt William D. Roland 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important; If item 27 is
any injury or other trau 5108 Bonnie Brae Ct. Ellicott City, MD 21043 Holly Hnat Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland May 21, 2009 Meadowridge Memorial Park, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ALZHEIMER'S DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the burial Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 🗖 No 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2**X** No 1 ☐ Yes 2 ☐ No 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 **X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the I 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) X Nurse Practitioner stated. To the h 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier

AGNES DAVIS

2009

State Registrar

DHMH 17 Rev 1/2001

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ompleted chase of death (Item 23a) (Type, Print) 30. Name and

> 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:00 a Mildred I. Eldridge May 11, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Hanover 7606 Harmans Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 ☑ F Maryland Director Jul 14, 1932 215-30-7442 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Mulcal Evantment institut by natified at 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 1 Yes 2 □ No **Funeral Director** Hanover Anne Arundel Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21076 U.S.A. 7606 Harmans Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ⊟Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. þ Specify: Black 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) District Government Federal Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grant Warren Edna Warren ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7606 Harmans Road Hanover, Maryland 21076 John Eldridge 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Md. 05/18/09 4 ☐ Donation 5 ☐ Other (Specify) Clownsville Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Ent or the disease, or complications that caused the shock, or cart failure. List only one cause on each line. Immediate Cadse (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician BIL /Medical Due to (or as a consequence of): Examiner EMEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending howevirum and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. 3 Probably 4 □ Nknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of eause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1100 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only oge) Hospital Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □ Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of centifier 29d. Date signed (Month, Day, Year) KENNETH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Year thimiou 01:17 Physician /Medical May NIKOlaos 21 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 F 6-24-1937 213-64-8272 Greece **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State 28a-f show 1 X Yes 2 ☐ No Director Baltimore MD Examiner must be notified 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ò 21224 U.S.A. 3734 Gough Street items 23a Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2x No Specify: White ģ 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Medical College (1-4 or 5+) Elementary/Secondary (0-12) is marked other than Restaurant Owner 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) or other traumatic event, Pages 1 and 2 should be fill ent of Health and Mental Hy It: If item 27 is marked oth Be Efthimiou Lambrini Giorgopoulou George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3734 Gough Street Balto. Maryland Anna Efthimiou - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State Nicholas Cem. 6-3-09 Department of Important: If any injury or once, Pappadates, Greece 4 Donation 5 Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 263 S. Conkling Street Balto. Md. 23a. Part I. Enter the disease, or ce pi rations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List nly ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VISIESS electrical **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) lor Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) resulting in death) Last Box 68760, physiciar Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy 1 Live birth Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No signed by the a Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 **- N**S 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) Hospital: 1 ☐ Yes 2 🖼 No 1 Inpatient 2 ER/Outpatient 3 🗌 DOA မ Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident the 1 Director; Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by City or Town, State) 4 Thomicide Hospital e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou

To the Funer

completely fi 2 Thedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)
MAY 2 2 2009

Lbironle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009 Registrar's Signature facel

600 North Wolfe St, Baltimore, MD, 21287

RES 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 20 MATY 2009 9:13A M ECKSTEIN TDA 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE TOWSON GILCHRIST HOSPICE CARE | Tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | SEP 10 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) <sup>Year)</sup> 1913 1 □ M **XX** F  $10^{pay}$ GERMANY 95 181-16-6750 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🙀 No BALTIMORE BALTIMORE 10f. Zip Code 21208 10e. Street and Number 25 GREENWICH PLACE 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Was Deced Armed Forces? 1 □Yes 2 No Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify. 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KUPFER REGINA HEINRICH GRUNEBAUM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25 GREENWICH PLACE BALTIMORE, MARYLAND 21208 NORMAN ECKSTEIN/SON 20c. Location - City or Town, State RANDALLSTOWN, MD 20b. Place of Disposition (Name of 20a. Method of Disposition CHEVRAY AHAVASOUCHESED 5/21/2009 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMISSIUM disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 □No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Rother (Specify) #65FILE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Physician /Medical **Examiner** 

attending physician and for use as the burial-transit

signed by the a

After this certificate

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

The law requires that the death certificate be executed

P.O.

of Vital Physician:

Division

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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MD

**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedfort Exyring in at I was beautified at once.

Baltimore, Maryland 21215-0036

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Examiner by Physician/Medical Completed Be Certification: To

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death

5 ☐ Pending investigation

6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

BALTIMORE, MO 21204

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

Medical

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certif

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. CHARLES ST, 8UTE 209 DANIEUE DOBERMAN, MD

31. Date filed (Month, Day, Year) State



Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F rtificate of a			giene <sub>1eg. No.</sub> 2009	16524
	Dhyaisi	-	1. Decedent's Name (First, Middle, La			<del></del>		2. Date of Deat Month	th Day Year	3. Time of Death
	Physici /Medio		Margaret Pa		lerlage	т.		MAY		
-	Examir	er	4a. Facility Name (If not institution, given Saint Joseph		Center		r Location of Deat	on		timore
	Funeral Director		5. Social Security Number 6. S 212-48-7228	Sex 7. Age ☐ M 2 💢 F	(In yrs. last birthday, 62 Yrs.	Months Days	If Under 24 Hrs Hours Min.			hplace (State or Foreign untry) imore, MD
	nud w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla	tor		imore	•	imore				1 ☐ Yes 2X No
	with the	Funeral Director	10e. Street and Number 8312 Wilson A	venue		10f. Zip Code 2123	34	1	10g. Citizen of What Co	untry?
980	be filed within 72 hours after death with the Maryland tial Hygiene. dother than "natural", or items 23a or 28a-f show event, the Modeal Exprirence, ust be mothed at	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	lispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
21215-0036	within 72 hor jene. r than "natur. the Medical I	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	(Give	edent's Usual Occup e kind of work done DO NOT use retired eli Mana	during most of wo d)		Grocery S	•
	o 7 0 5	To Be C	17. Father's Name (First, Middle, Last Walter Alfred					me (First, Middle, i		
2	ages 1 and 2 should be fi int of Health and Mental F t: If item 27 is marked ot y or other traumatic ever	1	19a. Informant's Name/Relationship (		i	ing Address (Street  3 Overle			or, City or Town, State, 2	
Baltimore,	Pages 1 ar nent of Hea int: If item iry or othe		20a. Method of Disposition  1 □ Burial 2 🎗 Cremation 3 □  4 □ Donation 5 □ Other (Specia		20b. Place of Disp cemetery, ca Evans F Chapel	matory or other place	ce) 05/2	Date 2 0 /09	20c. Location - City or Forest Hi	
Balti	permit. Pages 1 Department of I Important: If ite any Injury or of once.		21. Signature of Funeral Service Lice	m evc	I IN E	2. Name and Addre	neral C	hapel & Ci l. Parkvill	remetion Ser le, MD 21234	rvices 1
The same	Physician /Medical	(A )	2/ a. P rr1. Enter the disease, or come s lock, or heart failure. List only Immeriate Cause (Final disea e or condition resulting in death)	a.	the death. Do not er	nter the mode of dyi	ng, such as cardia	c or respiratory an		Approximate Interval Between Onset and Death
A	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, beauting to manufact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or ease	consequence of):  consequence of):					
O. Box 68	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown	23c. If yes, outcome of University 1 University 1 University 2 Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date of de Month	livery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions of CHRONIC OBST	· ·				1	obacco use contribute to ⁄es 2 □ No 3 □ P	o the cause of death?
l Records,	The law requate has been page 2 should	Completed								utopsy findings available completion of cause of
Vital	sician: The certificate rector, pag	Be (	25. Was case referred to medical examiner?					ath (Check only or	ne)	
of \	this al di	은	1 ☐ Yes 2 No  27. Manner of Death		nt 2 ER/Outpatie		4 🗀 Nursing	-	dence 6 Other (Spe	ecify)
o	of the ne	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, Day	(Year)	Wor	k? ]Yes 2□No	Zou. Describe n	now injury occurred	
=	tal or Attendii s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	e 280 Place of Inju	ry - At home, farm, st . <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
1	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one) 1 Certifying P edical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or i	th occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	is stated. e to the cause(s)
6	To the within To the complete	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
				Know		D37	7254		5/19/	09
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type			*	200	
		M W	31. Date filed (Month, Day, Year)	7 32. Registra	rs Signatura	- DRIVE	TOWSO	Y, MARYLI	AND 21204	
	Sta Registi		MAY 2 2 2009	32. Hegistra	A. Say	La P				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, perPHYS, 6891, 5/22/09, WS

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:00 A MAY 16. HELEN LORENE FREEZE 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 3011 Church Lane White Hall Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 ☐ M 2 🕱 F 1908 Indiana 220-34-5689 100 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County ral", or items 23a or 28a-f show Examiner inust be notified at 1 ☐ Yes 2 🙀 No Director Harford Maryland White Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, Ite Macal Equinity in at lear ury or other traumatic event, Ite Macal Equinity. 21161 USA 3011 Church Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify: Specify: 2 3 ☑ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesperson Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Hamilton Miller Maggie Lee Tabor ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1410 Kahoe Road, Forest Hill, MD 21050 David L. Wiley / Grandson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of P
Important: If ite
any Injury or ot Burial 2 Cremation 3 Removal from State 5-20-09 Highland Cemetery Street, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Service Licensee Slig (usa Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Heart Failure immediate Cause (Final **Physician** disease or condition resulting in death) TOTAL /Medical Due to (or as a consequence of) Examiner Inanition Sequentially list conditions, it are to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conse wence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 2 000 1 ☐ Yes 2 🕡 o certificate 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 10 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MAY, 18, 2009 D39763 Les Faneron MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2012 Tollgate Road, Ste 102, Bel Air, MD 21015 LCE TANNEY BAVM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Gener S. Sall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 6&10state of Maryand /5Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 0953 DELIMA GERZHOY 18 05 09 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death BARTMORE Umm SHOCK TRAMA 8. Date of Birth (Month, Day, . Social Security Number 7. Age (In yrs. last birthday) 76 Yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Min. Months Days Hours 220-35-3058 EM 2XX AZĔŘBĂJAN SÉP 14 1932 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No BALTIMORE N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number <del>21115</del> 21215 USA 6000 PARK HEIGHTS AVE #2A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married WHITE If Yes, Give Year or Dates: 1 □Yes 2X□No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOOD PRODUCTION **ENGINEER** 18. Mother's Name (First, Middle, Maiden Surname) VERA KHARITANSKY 17. Father's Name (First, Middle, Last) ISAAC **SELTZER** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6000 PARK HEIGHTS AVE #2A BALTIMORE, MD 21215 SERGEY GERZHOY/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State OHEB SHALOM MEM. PK. 5/21/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Source Literature 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MUTIPUT ORGAN DAY disease or condition resulting in death) Due to (or as a consequence of): DAYS Sepne SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DAYS (IMEYOBALTER Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Day Year 23e. Did tobacco use contribute to the cause of death? Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 7BRILOGTON autopsy 2 2 No 1 ☐Yes 2 🕅 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one, STAIRS

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Box 68760 attending ph for use as th

Bivision of Vital Records, P.O.

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Completed by Funeral

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natures" any injury or other traumatic excessions.

Examine Physician/Medical Completed by Be Medical Certification: To

s been signed by the should be detached

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within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral

1 ∐Yes 2 MNo 9	9 Unknown	o 🗆 o ino. (opcony)
art II. Other significant condition	s contributing to death but not resulting in	n the underlying cause given in

1 Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Res	sidence 6 Other (Specify)
27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  2 Homicide	on 04 30, 2009 1945 M	Work? 1 □ Yes 2 No SYNCO  ffice 28f. Location City or To	e how injury occurred  WE AND MIL DOWN STAIRS  (Street and Number or Rural Route Number)  SWIN, State)  WETH CHARLES SO BOTMINE MP
	Physician: To the best of my knowledge, death occurred at aminer: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, and due to th	
29b. Signature and title of certifier		icense number	29d. Date signed (Month, Day, Year)

2 2 2009

NVI 1447419247

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BMS 22 SOUTH GROW ST CVIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Herman Edward Gunn 2000 : 40E MA 3. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Baltimore Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 19, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XXM 2□F Director 213-32-7669 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Department of Health and Mental Hyglene.

Inductant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, "Ita Musical Exprinter must be notified at once. 1 ☐ Yes 2 X No Director Md. Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 USA 212 Aigburth Rd. Apt. 116 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2√20XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: Specify: þ 3 Widowed ANDivorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Supply Co. Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary DiBlasi Herman Gunn ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8661 Ridgelys Choice Dr. Baltimore, Maryland 21236 Mr. Oscar R. Mundy/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Gremation 4 ☐ Donation /5 ☐ Other (Specify) Dulanev Vallev Mem. Grd. 5/23/09 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. I or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Final disease or condition resulting in death) - Physician SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner SEPTIC ARTHRITIS OF BOTH SHOULDERS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi) Hospital or Attending Physician; The law requires that the death certificate be executed burial-tra Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical the as attending asn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day Month Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ ACUTE ON CHRONIC RENAL FAILURE 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 200 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Projistrar's Signature

DRIVE TOWSON, MARYLAND

09-03954 Arnold Stuart Gayle

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 16528

			- For State egistrar			Certific	ate of l	Death					eg. No.	State 147	3. Time of Death
	sicia	n/ 1	. Decedent's Name (First, Midd	le,Last)		N V/I I					2.	Date of Dea Month May 18, 2	th Day 009	Year	1116 hrs
dical Ex	amir		ARNOLD  la. Facility Name (if not institution	on oive street and		SAYLE_	46	. City, Tow	n, or Lo	cation of	Death	iviay 10, 2	4c. Col	unty of Dea	ath
			5384 Smooth Meado		,			Columb	ia				How		
Fun	eral	. 5	5. Social Security Number	6. Sex	7. Age (	In yrs. last bi	rthday)	If Under	1 Year Days	If Under Hours	1.50			Fore	
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the Ma	ified	Director	5384 SM00TH	MFADOW W	AY #3	4		21	044					USA	
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5-0 Tled w Hygie	th the		17. Father's Name (First, Middl		<b>1</b> .C		GAYL	_	'	ESTI		First, Wildere	, Maidell Cal	ELM	1AN
2121: ould be fil	narke	To Be	OSCAR  19a. Informant's Name/Relation	DOUGL nship (Type, Print		1	19b. Mailing	Address		and Num	ber or Ru			or Town, St	tate, Zip Code)
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Baltimore, MD bermit. Pages 1 and 2 sho	Important: injury or otl	Ī	2 . Signature of Funeral Service	Licensee				lame and A			50	L LEV	INSON	& BRC	OS., INC. F. MD 21208
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ital ician:	his certificate b	Be	25. Was case referred to med examiner?	Hospital:	1 Inpatie	ent 2 E	R/Outpatier		OA	Other;		ng Home 5	Residen	ice 6 🗸	Other: Scene
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Div	24 hours afte Funeral Dir stely filled in	်	4 Homicide	Dhusisian To	be best of m	w knowledge	death occ	urred at the	e time. c	date and p	olace, and	d due to the	cause(s) and	manner a	as stated.
E E	within 24 hours To the Funeral completely fille	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical I	Examiner: On the	basis of exa	mination and	d/or investig	ation, in m	y opinio	n, death c	occurred	at the time,	ate and plac	ce, and due	e to the cause(s)
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			30. Name and address of per				<sup>23a)</sup> 111 Per	n Stroo	F Bal+	impre !	MD 21	201			
			Laron Locke MD.	Assistant M					ı, Dail	ו אוטוווו, פ	VID 21.				
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09-03	3942
Allen	Hicks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle Last) Physician/ Month Day May 18, 2009 Medical Examiner 0353 hrs Allen Melbourn Lee Hicks 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Pilot Truck Stop #179 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday **Funeral** Country Months Hours Davs Director 585-62-6101 12/02/1951 New Mexico 57 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits any 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No 23a or 28a-f show TX Big Spring Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 512 E. 15th Street 79720 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 1 X Yes If Yes, Give Year 3 Widowed 4 X Divorced Yes 2 X No specify: Specify: White 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. other tranmatic event, the Medical Baltimore, MD 21215-0036 other than Truck Driver Produce 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked Be Allen Lee M. Hicks Nadia Fave McCabe 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is Sherri Hicks/Daughter Ε. 15th Street, Big Spring, TX 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
Ardent Cremation Services Burial 2 X Cremation Removal from State permit. Pages Department of Important; II 05/22/2009 Hanover, Maryland Donation 5 Other Specify 9 22. Name and Address of Facility Injury 21. Signature of Funeral Service Licensee Ardent Cremation services M01197 Hardes 7522 Connelley Drive, Ste.N. Hanover, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, and or Atending Physician: The law requires that the death certificate be executed Physician/Medical 23a,27,perME, g891 5/26/09 TI XUNPENDED the attending physician ed for use as the burial 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Year Live birth cate has been signed by the attending page 2 should be detached for use as Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes 2 No After this certificate Yes 2 To the Hospital or A tending Physician; I within 24 hour after cleath.

To the Funeral Director; After this certific completely filled in by the funeral director; 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 18, 2009 O.C.M.E. of death (Item 23a) 30. Name and address of verson who completed cause Assistant Medical Examiner Pamela E. Southall, MD 111 Penn Street, Baltimore, MD 21201

Registra

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17 per fh g891 5-22-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Ye ar **Physician** 05 2009 Verus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Year | If Under 24 Hrs. Umm 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. 1 □ M **3**√□ F Director 214-44-4024 30 63 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Event instructional be putified at once. 1 TYes 2 □ No Funeral Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 7806 Carmel Circle 21244 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) School System 12th grade 6yrs+ Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Van ပ္ Gloria Hairston William Welch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90292 19a. Informant's Name/Relationship (Type. Print) 4712 Admiralty Way #858, Marina Del Rey, Zina Welch-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge 5/23/09 Pikesville, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Metostatic breast /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 12 No the 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No r this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To I Director: After this ed in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Physician B17453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Tear) Brown Green St Baltimore egistrar's Signature 32 State 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registral Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2000 Dorothy Margaret Hatcher 1/(21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Koseda If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number yrs. last birthday) 8. Date of Birth (Month, Day, Year) 08/21/1932 7. Age ( **Funeral** Months Days Hours 1 □ M 2 🛛 F 76 243-48-5978 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanther must be notified at once. Maryland Baltimore **Funeral Director** Essex 1 ☐ Yes 2XXXVo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21221 960 Renfrew Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □No Specify ģ Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Sales Associate Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Mae Bolch Shuford Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 536 West Woodlynn Road, Baltimore, Maryland 21221 Tina Meadows (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 05/23/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Fun all Sarvic dicensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** evere /Medical Due to (or as a consequence of): Examiner euronia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 $ec{>}$ Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ∐Yes 2 XX No 9 Unknown 9 Unknown been signed the should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has autopsy performed? 1 Yes 2 No certificate this certific Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident Director: d in by the 1 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Medical 29a, Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number UD, (MARWAUA)

₹ State

Registrar
DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr 2891 5-22-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 18РМ Anna Patricia Houston May 2009 3:25 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) n/a Baltimore Good Samaritan Nursing Center H Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day Year March 31, 1918 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Maryland 1 □ M 2 X F 91 213-01-6716 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 1 ☐ Yes 2 X No Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21236 3826 Deckerts Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Zamenski Agnes (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21212 Raleigh Moss Jr./nephew 523 Rossiter Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Green Mount Crematory May 20, 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mitchell-Wiedereld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 Baltimore, MD 6500 York Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ELAONIA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 2 40 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩6 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Department of Important: If it any Injury or conce.

Physician

Examiner

**Funeral** 

Director

-how

rthen "natural", or itame 23a or 28e-f ehor the Medical Exeminer must be notified at

within 72 hours after

e filed within al Hygiene.

Pages 1 and 2 should be fil Iment of Health and Mental H tant: If item 27 is marked oth

Maryland 21215-0036

Baltimore,

Direct

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Completed

Be

/Medical

physician and the burial-transit use as attending for use as signed by the a d be detached f certificate has b irector, page 2 sl has director, this After thi funeral of death.

Examine Physician/Medical IF FEMALE: 2 Completed Be ၉ 27. Manner of Death Certification: 1 Matural 2 Accident 3 🗀 Suicide 4 Homicide 29a. Certifier

within 24 hours after death To the Funeral Director: completely filled in by the Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records,

P.O. Box 68760,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be

29c. License number 1)58570

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) May 19 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terrance L. Baker MI)

5601 Loch Raven Blvd. Balto. Md. 21239

State Registrar

32. Registrar's Signature 31. Date filed (Month; Day, Year) 2 2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

9-03911 Douglas Lee Harris		rris	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene					
ouglas Lee Hams			1- For State Registrar  Certificate of Death Reg. No. 2009 155					
Physiciai Medical Examin		an/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month May 16, 20		3. Time of Death 1822 hrs	
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 31 Sollers Point Road Dundalk					
Funeral Director			5. Social Security Number 216-98-9636 6. Sex 1X M 2 F 42 Yrs. 1f Under 1 Year 1f Under 24Hrs. 8. Date of Birth (MM/DD/YY Months Days Hours Min. Feb. 2, 1967)			Foreig		
	hours after death with the Maryland natural", or items 23a or 28a-f show any Examiner must be notified at once,	by Funeral Director	Usual Residence of Decedent  10a. State	cation			10d. Inside City Limits 1 Yes 2 X No	
			10e. Street and Number	10f. Zip Code	109	g. Citizen of What Cou		
1			5419 Princess Drive 21237 USA					
1			1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,	
			1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:		Specify: Wh:		
	hours "natur	ted k	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind of v g most of working life. DO NOT use reti		16b. Kind of Business/	Industry	
	, MD 21215-0036 and 2 should be filed within 72 hours aftereatht and Mental Hygiester than "matural", transact is marked other than "matural", traumatic event, the Medical Examiner	To Be Completed	9th Dis	patcher		USCO Co	o.	
			17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)					
	2121: hould be fill and Mental E is marked		Marshall B. Harris  Donna  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
	F = = = =		Marshall B. Harris /father 7555 Westfield Road Balto. MD 21222  20a. Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date   20c. Location - City or Town, State					
			1 XBurial 2 Cremation 3 Removal from State Oak La	- ather steen)	21/09	Baltimor		
	Baltimo permit. Page Department o Important: injury or oth		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	22. Name and Address of Facility 3.0	0 Mace	Ave Bal	Ito MD	
			21. Signature of Funeral Service Licensee  22. Name and Address of Facility  300 Mace Ave. Balto. MD  Connelly Funeral Home of Essey 21221  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval					
	Physician /Medical	0	failure. List only one cause on each line.  Immediate Cause (Final disease a. Heroin intoxication  Between Onset and Death					
	xaminer		or condition resulting in death)  Due to (or as a consequence of):					
		Physician/Medical Examiner	Sequentially list conditions, Due to (or as a consequence of):  cause. Enter Underlying Cause					
	d =		Chisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
	ox 68760, and certificate be executed attending physician and or use as the burial - transit		d					
			IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery				ry	
	on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be eath.  or: After this certificate has been signed by the attending physici the funeral director, page 2 should be detached for use as the buri		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	ancy	Month	Day Year	
	that the death	hysi	1 Yes 2 No 9 Unknown 9 Unknown		OO- Did to		the accuse of death?	
	P.O.		Part II. Other significant conditions contributing to death but not resulting in the	the underlying cause given in Part I.		2 ✓ No 3 Pro	bably 4 Unknown	
	ords, P w requires the street signs should be d	letec			24a. Was a		utopsy findings available completion of cause of	
	Reco The law cate has page 2:	ertification: To Be			perform 1 <b>V</b> Yes 2	ned? death?		
	1 of Vital Rec ling Physician: The After this certificate funeral director, page		25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene					
	of Vi ing Physi After this uneral dir		27. Manner of Death  28a. Date of Injury (Month Day Year)  (Month Day Year)					
	ivisi or Att after de Direct		Natural 5 Pending Fd 5/16/09 Fd 5:56 pm 1 Yes XX No U			unk		
			Homicide (Specify)			rs Point Rd		
4	To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	F 3 F 8	Me	29b. Signature and title of Cartifier	29c. License number		29d. Date signed (Me	onth, Day, Year)	
			30. Name and address of person the completed course of death (item 332)	O.C.M.E.		May 17, 2009		
OCME			30. Name and address of person who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201					
	c	oto	31. Date filed (Month, Day, Year) 22. Registrar's Signature					

Registrar

09-03998 State of Maryland / Department of Health and Mental Hygiene Deborah Hoffman 1- For State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ **Medical Examiner** Deborah Lynn Hoffman 4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital 5. Social Security Number 6. Sex **Funeral** Director 214-92-3817 M 2 X F 45 Usual Residence of Decedent 10a, State 10b. County s 23a or 28a-f show e notified at once. Md. Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
anti: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 1729 Wycliffe Ave. Funeral 11. Marital Status Armed Forces? 1 Never Married 2 Yes 2 X No 4 X Divorced If Yes, Give Year 3 Widowed ş 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 12 17. Father's Name (First, Middle, Last) Be Michael Scholtes 19a, Informant's Name/Relationship (Type, Print) 7 Ms. Karen Mintiens/ Sister 20a. Method of Disposition ltimore, 1 Burial 2 X Cremation 3 Removal from State Important: I permit. Page Department Donation 5 Other Specify: 21. Signature of Funer Service Licensee Physician failure. List only one cause on each line. /M- dical aminer or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED attending physician or use as the burial Box 68760. 23b. Was decedent pregnant in the Live birth past 12 months? 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions o 2 of Vital Records, P.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death 2. Date of Death Month Day May 19, 2009 2258 hrs 4b. City, Town, or Location of Death 4c. County of Death Baltimore n/a 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) Foreign Hours Min Months Days May 9, CounMaryland 1964 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 x No Baltimore 10g. Citizen of What Country 10f. Zip Code USA 21234 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. White Specify: 1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Medical Disabled 18.Mother's Name (First, Middle, Maiden Surname) Sandra Burkhart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1916 Stockton Rd. Phoenix, Md. 21131 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 5-22-09 Hilltop Service Co. Towson, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Approximate Interval e, or complications that caused the death. Do not enter the mode of dy Between Onset and a Combined narcotic (fentanyl and morphine) intoxication Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23a,27,28a-f,perm,E g892 6/3/09 TT 23d. Date of delivery 23c. If yes, outcome of pregnancy Month Day Year Fetal death Pregnant at time of death 5 Other (Specify) 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed' No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other; examiner' Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 2 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Yea 28b. Time of Injury Certification: Natural Yes 2 X No unk Pending 5/19/09 Fd 10:10 Fd 2 Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1729 Wycliffe Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide residence determined Parkville, Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME O.C.M.E. May 20, 2009 who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. 32. Registrats Signature State

Registrar

certificate has

this

After

within 24 hours after death.

To the Funeral Director:

Hospital or Attending Physician:

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend 24a-27,29 per Dr. g891 5/22/09 kh Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Baby Boy Johnson

4a. Facility Name (If not institution, give street and number) 03 2009 1930 29 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number Center Medica Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 6. Sex 1 2 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Yrs. 50 03/29/2009 Director NIA MO Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Saltimore MO 10g. Citizen of What Country? 10e. Street and Number USA 21230 6 Pages 1 and 2 should be filed within 72 hours after death vanet of Health and Mental Hygiene.
and: If tem 27 is marked other than "ratural", or Items 23a ury or other traumatic event. It as Marical Examples mines. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ ★6
If Yes, Give
Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 ☐ No 21215-0036 Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIA NIA NIA NA Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson Delshon Ushley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore 3049 L orena ave 21230 Ashley Juh 20a. Method of Disposition mother MD Johnson 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4-7-2009 Balt MORE MA New ( 4 ☐ Donation 5 ☐ Other (Specify) alhedra 21. Signature of Funeral Service License 22. Name and Address of Facility Bradley - Ashton Funeral 2134 Willow Spring Rd. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prematurity Physician extreme /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical ihe I IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown à signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours af To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) P22915 3/29/09 30. Name and ddress of person who complet (cal se of death (Item 23a) (Type, Print)

State

Registrar

ul Place

21202

301 St

M.D. 301 32. Registrar's Signature

Leneur

Daley

31. Date filed (Month, Day, Year)

amend #26 Per Print in Black Indelible Ink. Ensure All Copies Are Legible. Phy G891 5/22/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 50h 2009 John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A If Under 24 Hrs. f Unde 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Davs Months 1 M 2 □ F Yrs 226-38-7002 Director Dec 1, 1934 Maryland 74 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating in ast be medical and pines. 1 X Yes 2 □ No Director Baltimore Maryland n/a 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21217 712 Newington Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 
Yes 2 
No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 🛪 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify 2 Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Construction Company College (1-4or 5+) Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Herman Holland Josephine Collins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 McCulloh Street-2nd fl. Baltimore, Maryland 21217 Lucille Collins 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lansdowne, Maryland 05/27/09 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signature di uneral Service licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 212 Approximate Interval Between Onset and Death 282 Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Atheroscicrotic Cararolasce disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 □No ned by the a 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an PENTENSION autopsy certificate 1 ☐ Yes 2 No 2 NO 1 Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Sether (Specify) 2 🖪 No 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A letely filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of feath (frem 23a) (Type, Print) dr 22 BOLT, MORE. MD 31. Date filed (Manth, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

22

32. Registrar's Signature

GREEN ST

Beltimore mi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

Jandra Ruby,

MAY 9 9 2000

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decem 2. Date of Death 3. Time of Death nt's Name (First, Middle, Last) 19, 2009 4:10 PM **Physician** /Medical Facility Name (If not institution, or Location of Death 4c. County of Death Examiner reswick Multi Care Center more 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 11.12.1903 1 □ M 2 □ F 105 Director 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show MD 1 Yes 2 No notifled Director Fromit 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō traumatic event, the Medical Examiner must be 21215 usa 23a arrison Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 o, 1 ☐ Yes 2 ☐ No Specify: Blac ģ 3 Widowed 4 ☐ Divorced "natural" Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) than College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglent Important: If Item 27 Is marked other that any injury or other traumatic event, the Nonce. omestic oth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be Liza ames ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ean Norri . Garrison Ave., Balto., MD Baltimore, Salisbury. N 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service License Greene funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DemEntlA **Physician** Enn STAG /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 I Inknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ HPAYI 25 TIVE 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed ex Tunsior 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? Yes 2 certificate Vital 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20110 1 Inpatient 2 ER/Outpatient 3 DOA ဥ Division or To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director; After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 035102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North CHANTES Street 590

State Registrar

DHMH 17 Rev 1/2001

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09-03865 Heny Kishbaugh	Please Type or Print in Black Indelible In State of Maryland / Department of	Health and Mental Hyglene	ole.
	1- For State Registrar  1. Decedent's Name (First, Middle,Last)	Death Reg. 2. Date of Death	No. 3. Time of Death
Physician/ Medical Examiner	Henry A. Kishbaugh <del>, Sr.</del>	May 15, 200	
	4a. Facility Name (if not institution, give street and number)  4th Franklin Square Hospital	o. City, Town, or Location of Death Rosedale	4c. County of Death Baltimore County
Funeral Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24Hrs. 8. Date of Birth (I Months Days Hours Min. 4/5/1	MM/DD/YYYY 9. Birthplace (State or Foreign Country) PA
32 und show any ace.	Usual Residence of Decedent  10a. State	Toronto	10d. Inside City Limits 1 Yes 2 X No
with the Maryland as 23a or 28a-f shore notified at once real Director	10e Street and Number 231 Ridgeland Drive	43964	. Citizen of What Country? USA
er death with the Maryland , or items 23a or 28a-f show r must be notified at once. Funeral Director	11. Marital Status 1 Never Married 2 X XMarried 1 Never Married 4 Divorced lif Yes, Give Year 1 Never Married 4 Divorced lif Yes, Give Year	Decedent of Hispanic Origin? (Specify Yes or Noses, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2XX No specify:	14. Race - American Indian, Black, White, etc.  Specify: White
nours after a state of the stat	Tor Dates:	's Usual Occupation (Give kind of work done ost of working life. DO NOT use retired)	6b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 0	Truck Driver	Transportation
21215-0036 uld be filed within 7 Mental Hygiene. marked other than revent, the Medica	William Kishbaugh		baugh
MD 213 d 2 should to this and Men an 27 is mar aumatic eve	Regina Kishbaugh / Wife 1993 Majiling 23	Address (Street and Number of Rural Route Numb Ridgeland Drive, Tor	conto, OH 43964
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If itten 27 is marked other than "natural", or item injury or other traumatic event, the Medical Examiner must injury or other traumatic event, the Medical Examiner must in the Medical Examiner must injury or other traumatic event, the Medical Examiner must injury or other traumatic event, the Medical Examiner must be a completed by Fune	1 Burial 2 Cremation 3 X Removal from State Ft. Steu	her place) 5/20/09 ben Burial Estates	Wintersville OH
Baltin permit. P Departme Importar	21. Signature of Euneral Service Licensee Victor Doda Ch	lame and Address of Facility arles L. Stevens Fun 01 E. Fort Avenue, B	eral Home, Inc.
Physician Medical aminer	23a. Part I. Enter the disease, or semplications that caused the death. Do not enter the failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic card		Between Onset and Death
iaiiiiei	or condition resulting in death)  Due to (or as a consequence of):  b.  Sequentially list conditions,		
insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated essentiation in death). Lest Due to (or as a consequence of):  C. Due to (or as a consequence of):		
and and transit	u	r ME g892 6/3/09 TT	
D, the exestician sician purial -	XUNPENDED X AMENDED #1,23a.27, pe		23d. Date of delivery
Box 68760, e death certificate be ex- the attending physician ed for use as the burial-	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 0	etal death 3 Ectopic pregnancy ther (Specify)	Month Day Year
O, Box at the death cdby the attentated by the attentated for us	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial-		24a. Was a autop perfor	an 24b. Were autopsy findings available
Rec The ificate		26.Place of Death (Check only one)	2 103 2 103
/ital /sician nis cert directo	examiner? Hospital: A lengtion 2 of ER/Outpatier	1 3 BOX	Residence 6 Other:
of Vital Rec	27 Mapper of Death 28a Date of Injury 28b. Time of	Injury 28c. Injury at Work? 28d. Describe	how injury occurred
Division tal or Attendi rs after death. al Director: /	Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		Street and Number or Rural Route Number, City state)
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		urred at the time, date and place, and due to the causation, in my opinion, death occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To 1 To the	(Check only one)  2 Medical Examiner: On the best of my knowledge, dealth occurred one)  2 Medical Examiner: On the basis of examination and/or investig and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	anete	O.C.M.E.	May 15, 2009
	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201	
Sta		, ,	
Registr DHMH 17 Rev 1/200	MAIN DE COOR PORCOS P. MOUNT	AL	

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State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Again 1. Ag

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

MANDEEP

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:30 A M Mary Laura Kneeland May 17, 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗙 F NY Director 132-18-2681 81 Jan 14, 1928 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show the Medical Exertiener must be notified at 1 □Yes 2 Director Glenelg MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or Pages 1 and 2 should be filed within 72 hours after death with 14104 Bison Ct. 21737 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Was Deceud... Armed Forces? 1 □ Yes 2 No Black, White, etc. 1 Tyes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, I'm 1000. Homemaker **Own Home** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael S. Capone Anthonina Castro ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13401 Peachwood Ct. Fairfax, VA 22033 Lisa Neifert Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) May 22, 2009 Clarksville, Maryland Columbia Memorial Park 21. Signature of Funera 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. Ust only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rduolespir /Medical to (or as a consequence of): Examiner monu if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 3 Probably 4 Unknown 1 🗀 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) s after death.

I Director: After this ce
of in by the funeral direc Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 [] Inpatient 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire completely filled in b 1 (LertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

82. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 03:22 J. Mzy 2009 Dennis 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospit = If Under 1 Year If Under 24 Hrs. ). hus Holkin, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex last birthday) 7. Age (In yrs Funeral Months Days Min. 1**x** M 2□ F Hours 216-54-2600 Director 9-4-1951 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County nd 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. Z7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the McGen Eximiner must be notified at 10a. State 1 XYes 2 ☐ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 3131 Elmora Avenue 21213 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2K No Black Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sunpapers 12th grade Mailroom Foreman years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arnita Mitchell permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Carl Bernard Lindsev 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tiffany Lindsey-Daughter 4205 Sheldon Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem 5-27-2009 Balto, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H 1101 E. North Avenue Balto, MD 21202 oner Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lingenic /Medical Due to (or as a conse mence of): Examiner Sequentially list conditions, in any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to force a consequence of Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No for 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' within 24 hours after death. To the Funeral Director; After this certificate I completely filled in by the funeral director, page 2 No 1 ☐Yes 2 ☐ No 1 Yes 25. Was case referred to medica examiner? 26. Place of Death (Ch. ck only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State Registrar

5

29b. Signature and title of certifier

Brandon

31. Date filed (Month, Day,

ack

600

MD

Registrar's Signature

RUMA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ogioka

Year)

29c. License number

RES-000

W.Ife

Street

29d. Date signed (Month, Day, Year)

2009

21287

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For	Please <sup>-</sup>	<b>Type or Prin</b> State of Ma		/ Depa	rtment of H	lealth and N		•	ible.	1651.3
		Registrar	e (First, Middle, Last	·)		Cer	tificate of I	Jeath	2. Date of Dea	Reg. No. 4	707	3. Time of Death
Physicia /Medica		WING	CEE LEE						Month MAY	Day	Pear Par Par Par Par Par Par Par Par Par P	Ø8:35AM
Examine			f not institution, give Joseph			er	4b. City, Town, or	Location of Death		4c. County		imore
Funeral Director	- 1	5. Social Security N 218–26–05	80 X	TM 2DE	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept 11	, Year) , 1920	9. Birthp Coun Chin	
yland now		Usual Residence of 10a. State	10b. County		10c. City, To	own or Lo	cation				10	Od. Inside City Limits
Ba-fst	ector	Maryland	None		Ва	ltimo				10- Citi1	XX Yes 2 □ No	
3a or 2	١	10e. Street and Nur 6217 Marl					10f. Zip Code 212	39		10g. Citizen of What Country?		
Irs a	d by Funeral Director	11. Marital Status	ied XXMarried	12. Was Decedent Armed Forces? ************************************	Ever in U.S.	1	Vas Decedent of H fYes, specify Cuba □ □ Yes ※ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americ ack, White, e	etc.
72 hou "natura	eted	(Spec	15. Decedent's Edu cify only highest grad	ication le completed)	1	6a. Deced	lent's Usual Occup	ation during most of work	king	16b. Kind of E	Business/Inc	dustry
l within giene. r than	dwo	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)	iite. L	Owner	1)		Resta	aurant	
uld be filed Mental Hyg Irked other Itic event,	To Be Completed	17. Father's Name MOO Lin L	(First, Middle, Last)					18. Mother's Nam Cee Ng	e (First, Middle,	Maiden Surna	me)	
nd 2 sho alth and I 27 is ma rr trauma		19a. Informant's Na David Le	ame/Relationship (7)	ype. Print)				and Number or Ru Drive Ab:				
ges 1 al t of Hex If Item or othe	Ì	20a. Method of Disp	position □ Cremation 3 □	Removal from State			sition (Name of natory or other plac		Date	20c. Location	-	
artmen ortant: Injury		4 ☐ Donation	5 □ Other (Specify	1	Lorra							Maryland ral Home Inc
Dep Imp any onc		Down	styph	entles	udelle	6		500 York				
Physician		shock, or hea Immediate Cause disease or condition	the disease, or comp art failure. List only o (Final on	ne cause on each li	d the death. Ine.		er the mode of dyir HE LUNG		or respiratory ar	rest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		,	a consequen		TASTASE	S				
D ±	ner	Sequentially list confidence if any, leading to implementation cause. Enter Under Cause (Disease or	enditions, nmediate erlying	b	a consequen							
icate be executed physician and the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	5	c Due to (or as	a consequen	nce of):						
ate be hysiciar he buri	_		•	d								
ath certif attending for use as	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months?	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal de	eath 3	Ectopic pregnanc Other (specify)	у			ate of deliver	ery Day Year
uires that the density and signed by the a	þ	Part II. Other signit	ficant conditions co	entributing to death b	out not resultin	ng in the u	nderlying cause giv	en in Part I.	23e. Did to			ne cause of death?
The law require cate has been sit page 2 should b	Completed	***							24a. Was autop perfo 1 □ Yes		. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of
sician: Th certificate rector, pag	Be	25. Was case referexaminer?	/	Hospital: ,↓✓,			Oth	26. Place of Dea				
ding Phys h. After this funeral dii	on: To	1 ☐ Yes 2 ☐ 27. Manner of Deat 1 ☐ Natural		28a. Date of Inju	ury 28	Bb. Time of Injury	Wor	ry at k?	ome 5 ☐ Resident Properties 1			<u>y)</u>
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6 Could not be determined	1 Zoe. Place of In	jury - At home tc. (Specify)	e, farm, str	M 1 □	Yes 2 □No	28f. Location (S City or Tox	Street and Num vn, State)	nber or Rura	al Route Number,
the Hospital hin 24 hours a the Funeral I	Medical Ce	29a. Certifier (Check only one)		/sician: To the best iner: On the basis and manner si	of examination							
To the within To the compl	Me	29b. Signature and	title of certifier	Leloy 1	u. D	ν.	29c. Licens	e number 017695		29d. Date sign	ed (Month,	Day, Year) 2009
10 /		30. Name and addi	ress of person who o	completed cause of							170	orno orno il
Stat	е	31. Date filed (Mor		32. eğet	rar's Signatur	e _		KIVE TO	WSON, M	HKYLAN	VD 21	204
Registra	ar		MAY 2 2 20	09 Dene	n B	. A.	ales				_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 0626AM **Physician** 2000 Laurence Bruce Lesser /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HUNES HOSPITAL Himoret Ba 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 06/02/1944 Birthplace (State or Foreign Country) (In yrs. last birthday 7. Age **Funeral** Days Min 1 XM 2 ☐ F 64 095-36-5940 Vrs NY **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expranal register is set by once. Rockville MD Montgomery Y☐Yes 2☐No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20851 602 Twinbrook Parkway Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 □ Yes 2 🛣 No Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Consultant Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janet Capello Milton Lesser ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9005 Mears Street, Fairfax, VA 22031 Beverly Anderson / Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/23/2009 Hanover, MD Ardent Crematory 4 Donation 5 Dother (Specify) of Funeral Service Liversee Dorota Marshal P2. Name and Address of Eacility Cremation Services Workingth - W Po Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician atheroselotic copiosocular di disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to infined at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 HInknown 9 Unknown n signed by tl Id be detach∈ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≥</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 1 Inpatient Medical Certification: To this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely (Check only one) and manner stated.

Records, Physician: The of Vital Division or Attending within 24 hours after death To the Funeral Director: the Hospital

P.0.

altimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

DON.

Year

Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

255

Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

00

3

306

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner
Eunoval

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, To the Hospita or Attending Physician: The law requires that the death certificate be executed

ian	1 - State Registrar		ertificate c	ot Death	2. Date of De	Reg. No.	ZUU:	7 100			
	1. Decedent's Name (First, Middle, Last)					Day	Year 19, 200	3. Time of Dea			
al	JAMES CARROLL LOCKARD SR.		4h City Tour	n, or Location of De			County of Deal				
ner	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical C	enter		Tot	WSON		Bal	.timore			
	216-18-6005 <sup>1⊠M 2□ F</sup> 85	yrs. last birthd Yrs	Months   Da		in. 8. Date of Bi (Month, D	rth ay, <i>Year)</i> 3, 19		thplace (State or Fo buntry) Yland			
	Usual Residence of Decedent  10a, State 10b, County 10c.	. City, Town or	Location					10d. Inside City Li			
ō	Manual and Hamband	D-1 74	_					1 □ Yes 2 5			
Director	Maryland Harford	Bel Ai	10f. Zip Cod	e		10g. Citizen of What Country?					
0	10 Hunter Drive		2101			1	USA				
Funeral	11. Marital Status 12. Was Decedent Ever in	in U.S.	3. Was Decedent	of Hisnanic Origin?	(Specify Yes or N		14. Race - Ame	erican Indian,			
5	Armed Forces?  1 □ Never Married 2【 Married 12 No If Yes, Give Year or Dates:		If Yes, specify 0	Cuban, Mexican, Pu	erto Rican, etc.)		Black, White	e, etc. White			
ted	15. Decedent's Education		ecedent's Usual Oc			16b. Ki	nd of Business				
Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+)	lit	e. DO NOT use re Preside	/	working	Ban	nkina				
	17. Father's Name (First, Middle, Last)	VIC	c_rreside		Name (First, Middle						
o Be	Charles Edward Lockard	melia Llo	byc								
ဥ	19a. Informant's Name/Relationship (Type. Print)	19b M	ailing Address (Str	eet and Number or			r Town. State	Zip Code)			
				_				, 30/			
	James C. Lockard Jr. / Son  20a. Method of Disposition 20		Sposition (Name or crematory or other	y, Bel A	Date		cation - City or	Town, State			
	Burlar 2 Defermation 3 Differmoval from State			1	00.00			1 -			
	4 Donation 5 Other (Specify)  21. Signature of Juneral Service Lioens	<u>el Air</u>	Memoria 22 Name and Ac	Gdn 5-	23-09	Bel	Air, Ma	ryland			
	1 1/1/1/11 /16			dress of Facility Funeral			_				
	23a. Pa 1. Enter the disease, or complications that caused the c	death Do not	1317 Co	kesbury	Road, Ab	i ngdc	$m_{\star}$ MD_2	21009 Approximate			
	shock, or heart failure. List only one cause on each line.	death. Do not	eliter the mode of	uying, such as can	diac of respiratory	arrest,		Interval Betwee			
	Immediate Cause (Final disease or condition resulting in death)  a. RESPIRA										
	Due to (or as a consequence of):  FULMONARY EDEMA										
_	Sequentially list conditions, if any, leading to immediate	MINISTER STATE OF THE PARTY OF									
in	cause. Enter Underlying										
Examiner		c. ACUTE MYOCARDIAL INFARCTION  Due to (or as a consequence of):									
	CORONAR	Y ART	FRY DIS	EASE							
gi											
Physician/Medical	IF FEMALE:   23c. If yes, outcome of pregnancy   23d. Date   23d										
1 >	Part II. Other significant conditions contributing to death but not	t resulting in th	e underlying cause	given in Part I.	23e. Did	tobacco i	use contribute t	o the cause of deat			
			, ,		· ·	Yes 2	□No 3□P	robably 4 🗌 Unk			
by	VALVIII AD HEADH DECEACE				1.5						
by	VALVULAR HEART DISEASE						Lanus				
by	RENAL INSUFFICIENCY				24a. Wa	s an opsy	prior to	utopsy findings ava completion of caus			
	1-				24a. Wa	s an opsy formed?	prior to death?	completion of caus			
Be Completed by	RENAL INSUFFICIENCY  25. Was case referred to medical examiner?				24a. Wa	s an opsy formed? 2 No	prior to death?	completion of caus			
Completed by	25. Was case referred to medical examiner?  1 Yes 2 You Hospital: 1 Tempatient		ttient 3 DOA	Other: 4   Nursin	24a. Wa aut per 1 □ Yes Death <i>(Check only</i> g Home 5 □ Re:	s an opsy formed? 2 No one)	prior to death? 1 Yes				
To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Impatient  27. Manner of Death 28a. Date of Injury (Month, Day, Yea	28b. Tim	e of 28c.	Other: 4 □ Nursin njury at Vork?	24a. Wa aut per 1 ∐ Yes Death <i>(Check only</i>	s an opsy formed? 2 No one)	prior to death? 1 Yes	completion of caus			
To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2 No	28b. Tim Inju	e of 28c.	Other: 4 ☐ Nursin Injury at Work? 1 ☐ Yes 2 ☐ No	24a. Wa aut per 1 □ Yes  Death (Check only g Home 5 □ Re:  28d. Describe	s an opsy formed? 2 Sulp one) sidence	prior to death? 1	completion of caus s 20 No acify)			
ertification: To Be Completed by	RENAL INSUFFICIENCY  25. Was case referred to medical examiner? 1   Yes   2   No	28b. Tim Inju	e of 28c.	Other: 4 ☐ Nursin Injury at Work? 1 ☐ Yes 2 ☐ No	24a. Wa aut per 1 □ Yes  Death (Check only g Home 5 □ Re: 28d. Describe	s an opsy formed? 2 Sulp one) sidence	prior to death? 1	completion of caus s 20 No acify)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>009</u> Month 3:00 A M 18. Mav ₄i.sh Edith Irene 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Parkville Baltimore Oak Crest Care Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days Months 1 □ M 2 □ XF 24, 1924 Maryland 219-14-0282 85 Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Parkville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 U.S.A. Apt. 304N 8832 Walther Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Insurance Actuary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Blanche** Emma Watkins Fielding Lucas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10014 290 W. 12th Street, Apt. 4D New York, New York Connie Benwitt Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-20-2009 Moreland Mem. Park Baltimore Maryland re of Conoral Servi 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signal Licensee Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or comilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Debiletu Due to (or as a consequence of): Disease Alzheimers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 □ Yes 2 □ No performed 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🖳 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be execute certificate has been s rector, page 2 should funeral director, after death.

I Director: Af
d in by the fur

**Physician** 

/Medical

Examiner

Director

Funeral

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Certification: To

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Modical Examiliar must be recitled. Once.

Physician /Medical

Baltimore, Maryland 21215-0036

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n 24 hours after le Funeral Dire letely filled in b within 24 ho

To the Fune

completely 1

State Registrar

29a, Certifier

27. Manner of Death

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number R171944 29d. Date signed (Month, Day, Year)

5/18 2009

eted cause of death (Item 23a) (Type, Print)

CANP 9800 Walther Blvd, Parkville MD 21234 G. Harryon Michealle

31. Date filed (Month, Day, Year) MAY 2 2



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 65 State of Maryland / Department of Health and Mental Hygierie [ For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1º LEOA Day Month **Physician** 2:55 2009 TIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner [],4 IRVING TON BACTIMORE UTURE ARE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗑 F 250 - 34 - 8593 Usual Residence of Decedent 5.C. **Director** 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or than "natural", or Itema 23a or 28a-f show the Medical Examinar must be rediffed at 1 ☐ Yes 2 No Directo Ma. IMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2120 57. 65/1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify BLACK ۵ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) BON Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Hygiene. 1274 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event 20cg. To Be LAdden TNNA AddEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) te 20c. Location - City or Town, State 5% Md. 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen CREMARTIE FXS comulu MD- 2/223 Approximate Interval Between Onset and Death 235 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-transit certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, 1 🗌 Yes 20 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □ No 2 No 1 Yes 1 ☐ Yes Division of Vital or Attending Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tes 3 DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After 16 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All
completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. Tc the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1)23046

Registrar

State

Hamman of Fry Rel

30. Name and ad ass of person who completed cause of death (Item 23a) (Type, Print)

2)/) 32. Registrar/Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #24e Per Phy G892 6/03/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year BAUTISTA **Physician** JUAN MINAYA Mam 2000 /Medical Town or Location of Death 4c. County of Death 4b. City. 4a. Facility Name (If not institution, give street and number) Examiner Sec timone 8. Date of Birth (Month, Day, Year, 1 - 7 - 1943 If Under 24 Hrs. 9. Birthplace (State or Foreign SAY vrs. last birthday Year Min. DOMINICAN REPUBLIC Months Days Hours 1 M 2□ F 214-92-2379 66 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🙀 No Director BALTIMORE ROSEDALE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7927 1/2 35th STREET 21237 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status DOMINICAN 1 Never Married Married 1 □X/es 2 □ No Specify: HISPANIC Specify: \$ REPUBLIC 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) RESTAURANT CHEF 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANDRE MINAYA **GENOBEVVA** (ESPINAL) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) RAMONA MINAYA/WIFE 7927 1/2 35th STREET ROSEDALE, 21237 MD20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-24-09 BROOKLYN PARK, MD CEDAR HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 21237 1211 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) schemic Due to (or as a consequence of): onav Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner tension Due to longs a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Day Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ANO 2 □No 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the detached certificate r this certifica 24 hours after death.

Funeral Director: After the letely filled in by the funeral

**Funeral** 

Director

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ns 23a or 28a-f shor

ed other than "natural", or items event, the Medical Examiner ma

?7 is marked other traumatic event, II

permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other trai once.

**Physician** 

Pages 1 and 2 should be f nent of Health and Mental

Baltimore, Maryland 21215-803

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State Registrar

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Medic

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Print) 30. Name and address of person who

31. Dåte filed (Month, Day, Year)

29b. Signature and title of certifie

29a. Certifier

2 2009 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20a-c, per Fh g892 6/8/09 TT State of Maryland / Department of Health and Mental Hygiene Amend 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 20 Year **Physician** 085 an Meadows /Medical Walter 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1 M O C E Social Security Dumbe 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Min Months Hours 1**X** M 2□ F 71 **Director** 258**-**50-6568 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the "section Examination and the profiled a Y☐Yes 2☐No Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 U.S.A. 2811 Clifton Ave Funeral Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 MaYes 2 □ No If Yes, Give Year or Dates: Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 2 Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Laborer Parks & Recreation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 <u>Claudia M Dotson</u> <u>Walter Meadows</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra Baxter-Cousin 3627 Rosedale Road, Baltimore, Md 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 6/6/2009 ot 5/28/09 Baltimore, MD Owings Mill Carrison Fores Vet 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/h West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) . Physician atic Coschel /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine certificate be executed and Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the as for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier Name and address of person who completed cause of death (Item 23a) (Type, Print) ONNI 31. Date filed (Month, Day, Year)

MAY 2 2 2009 State Registrar

State Registrar 29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

Woods

29d. Date signed (Month, Day, Year)

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Kood -

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State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Maryland	Certificate of		Reg.	711119	16551
	Dissolution		Decedent's Name (First, Middle, L.)		1	2	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al -	MILDRED  4a. Fecility Name (If not institution, g	MC CAT		or Location of Death	MAY	18 2009 4c. County of Death	
	Examin	er	BON SECOURS	HOSPITAL	BA	ZTIMORE			
	Funeral Director	-	216-24-3598	Sex 1 M ASF 7. Age (In yrs. last	t birthday) If Under 1 Yea Months Days	r If Under 24 Hrs. 8 Hours Min.	Date of Birth	9. Birty 5,1925	place (State or Foreign untry)
	Maryland -f show	tor	Usual Residence of Decedent  10a State  10b. County	10c City, 1	Fown or Location  It in o re				10d. Inside City Limits 12 Yes 2 □ No
	h with the 23a or 28a at be noti	ai Direc	10e. Street and Number	silmor Stree	£ 10f. Zip Code 21	217		. Citizen of What P	untry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examination ust be notilised at	by Funeral Director	11. Marital Status  1 □ Never Married 2万Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2★ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 240 No	Hispanc Origin? (Spec ban, Mexican, Puerto R o Specity:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	within 72 ho ene. than "natur he Wouldal	Completed	15. Decedent's (Specify finity highest ( Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work don life DO NOT use retil	e durina most of workini		Heal	Industry
	ould be filed with Mental Hygiene. arkad othar tha atic evant, the hatic	To Be Co	17. Father's Name (First, Middle, La	st)		18. Mother's Name		siden fumame)	al
Maryland	1 and 2 should Health and Men tem 27 is marks other traumatic		19a. Jahrmand Nagle/Relationshi	romas daughted	19b. Mailing Address (Super 107 N. G.	more t	BAHin	City or Town, State, 2	d 21211
Baltimore,	0 0 = =		20a. Method of Disposition  1 Surial 2 Cremation 3  4 Denation 5 Other (Spe	Removal from State	ce of Disposition (Name of letery, crematory or other p	tery 5/22	109 2	e. Location - Oity or an Solace	rown, State
Balti	permit. Pag Department Important: any injury c		21. Ignature of Funeral Service in	e to Boan	22, Name and #	Fulton to	E BATT	E caperal	Home_
				emplications that caused the death.		ying, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical	1	nmediate Cause (Final disease or condition resulting in death)	a. SEPTICE  Due to (or as a conseque	m/A				
н	Examiner	_	Sequentially list conditions,	b. BILATERA  Due to (or as a conseque		mon/A			
10	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	nce oi).				
09289	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):				
687	ifficate g physias the	edical		d					
.O. Box	that the death certifed by the attending detached for use an	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3 □Ectopic pregnar			23d. Date of de Month	livery Day Year
0	Se US	d by Ph	Part II. Other significant condition	s contributing to death but not result  MEZUTUS	ing in the underlying cause	given in Part I.			o the cause of death?
Division of Vital Records,	elaw hasb je2st	omplete					24a. Was an autopsy perform	ed?_ prior to death?	utopsy findings available completion of cause of s
/ital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	Managhali		26. Place of Death	Check onl one		
of \	Phys this ral di	. To	1 Yes 2 10 27. Manner of Death		28b. Time of 28c. Ir	Other: 4 Nursing Hon	ne 5 🗌 Resider 8d. Describe hov		ecify)
ion	Attanding Ph r death. ector: Atter th by the funeral	ation	1 Accident 5 Pending investiga	tion		☐Yes 2☐No			D! (7
Divis	after de Directe d in by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, offic	ce 2	28f. Location (Stre City or Town,	eet and Number or F State)	lurai Houte Number,
-	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my know xeminer: On the basis of examination and manner stated.	ledge, death occurred at the on and/or investigation, in m	e time, date and place, a by opinion, death occurre	and due to the ca ed at the time, da	use(s) and manner a te and place, and du	is stated. e to the cause(s)
v.	To th within To th compl	Me	29b. Signature and title of certifier	, , o		ense number		d. Date signed (Mor	_
•	~		/ 0.	reller, ord	00-) (T B-i)	30272	1	TIMORE,	6009
	7		30. Name and address of person w	to completed cause of death (Item:	BON SECONS	S HOSPITA	L BA	MMORE,	NO.
	St Regist	ate	31. Date filed (Month, Day, Year)	Registrar's Signatu	BON SECOND	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** lee 11:05 AM Ma 2009 /Medical 4a. Facility Name (If not institution, give street and nur 4b. City, 4c. County of Death **Examiner** are ne If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 9. Birthplace (State or Foreign Sountry) (aroles 5. Social Security Number 6. Sex Jast birthday **Funeral** Days Months 1 □ M 2 😿 F 62 -62-**Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any fillury or other traumatic event, the Medical Evan 12Never Married 2 ☐ Married □Yes 2 No Yes, Giv Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No. p 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ 12th body 70 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ranto 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signiture of Funeral Service Licensee 22. Name and Address of Facility Nancy M. Wallace oo ale 23a. Par in Fmilit // disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final **Physician** Res male s e to (or as roonsequence o audes 2 hours resulting in death) /Medical Due to (or as Examiner pulmonary disease Obstructo Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner Condion 10 park

Due to (or as a consequence of): burial-tra P.O. Box 68760. Hospital or Attending Physician: The law requires that the death certificate be as the l IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 1 ☐ Yes 2 1 No 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, phlentonro 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 2 **12** No 1 □ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Dippatient 2 ER/Outpatient 3 DOA Certification: To Division of 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deatl 3 Suicide 6 □Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 20 WD Hossan Nasser D0053617

2 State

HASSAN NASSEA 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 East University 32.

Ballimon.

Registrar

9 Unknown

certificate be executed attending physician and for use as the burial-trar 62/81/So o Records, MC KINNON , ACKOLO this

Physician/Medical us certificate has been signed by director, page 2 should be detact 2 Completed Be Certification: To After t

Division of Vital death. To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A filled in by Medical

23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🖾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29c. License number

3 Ectopic pregnancy

5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

8:30 P M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 TolYes 2 □ No

North Carolina

14. Race - American Indian,

Black, White, etc.

Specify: White

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

Year

Month

State

Natasha P. Haag,

29b. Signature and tille of certifier

23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No

9 Unknown

in the past 12 months?

8600 Old Georgetown Road, Bethesda, Maryland 20814 M.D.32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) NAY 2 2 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:26 P. M Paul F. Mortillaro May 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 184 Clemencia Road Earleville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 88 219 01 5190 Maryland Director 09/14/1920 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 1 ☐ Yes 2 No Director Cecil Maryland Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 184 Clemencia Road 21919 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: by 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Institute Elementary/Secondary (0-12) College (1-4or 5+) of Health Cinematographer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carmelo Mortillaro Marie A. Rubino 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Specht / Daughter 184 Clemencia Road Earleville, Maryland 21919 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State State Veteran Cem 05/18/2009 Crownsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Jana 4001 Ritchie Highway Baltimore, Maryland 21225 as a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Listonly one cause or each ine. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** 1 /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No. 24a. Was an autopsy performed?

1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: hin 24 hours after death. funeral After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

The law requires that the death certificate be executed

physician and is the bunal-trans

ass attending p

the

g signed t

peens

has page 2

certificate

this

Department of Health and Mental Hygiene. Important: yor Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-00

Baltimore.

Pages 1 and 2 should be

permit.

State Registrar

Medical

29b. Signature and

Dr. Gloria Simonson

end manner stated.

111 High Street

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elkton, Maryland 21921

31. Date filed (Month, Day, Year) MAY 22 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #31 per DVR 8891 5/22/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** DYD 17.20pm . MULLINGAUX. 05 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENERAL COLUMBIA MD COUNTY HOWARD HOWARD COUNTY HOSPITA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 MM 2□ F Months Davs Hours Director 218-26-8227 Dec 29, 1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Events 200.000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Howard Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2571 Thompson Dr. 21104 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No if Yes, Give Year or Dates: 3/27/-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3/28/1951 1 ☐ Yes 2 No Specify <u>ک</u> Specify: 3 Widowed 4 Divorced White 3/27/1953 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Ralph H. Mullineaux Florence O. Troyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda M. Mullineaux Spouse 2571 Thompson Dr. Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 19, 2009 Ellicott City, Maryland Good Shepherd Cemetery re of Funeral Service Licen + e 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Soter the deepse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or AttendIng PhysIcian: The law requires that the death certificate be execute burial-tran Due to (or as a consequence of)  $\mathcal{HAHC}$ Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No NA within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 2 No 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mujahid mD. D59556 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) umera Mujalinel POCCA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

MAY 2 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Clara Mullineaux 8:00 AM May 19, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard 8701 Hayshed Lane Apt 32 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 K F Hours Director 212-42-1858 May 19, 2009 Usual Residence of Decedent 10a. State 10d. Inside City Limits 28a-f show 10c. City. Town or Location er than "natural", or items 23a or 28a-f sho 1 □Yes 2 No Director MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HOL 32 8701 Hayshed Lane 21045 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?/
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene.

ia marked other than "natural", or iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Business Owner** Janitorial Supplies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Warfield 2 Agnes unknown Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
important: If item 27 ia
any injury or other trau Martin E. Mullineaux Spouse 8701 Hayshed Lane Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 20, 2009 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory, LLC 22. Name and Address of Facility vice Licensee Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Part 1. Enter the disease, or complications that aused t shock, or heart failure. List only one cause on each line or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Minues /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but right resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 2. No 1 Tyes 1 Tes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ၉ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death Medical Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and file of certifie 29d. Date signed (Month Day, 29c. License numbe

State Registrar Lexu

100

30. Name and address of person who completed cause of death

KONNOY

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

950

em 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician  Michael State Control (Proposition Control				For State Registrar	State of M	aryland / De <sub>l</sub> <i>C</i>	partment of F <i>ertificate of I</i>		lental Hygie Reg.	2000	16557
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South South Flower South South Flower South Sout	And.	/Medic	al	A. Franklin Manager (Manager)					Мау	14, 2009	3:49 P
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Physician Medical Examiner    Sequential standard   Sequential sta	ľ			23a. Part 1. Enter the disease, or o	omplications that cause	ed the death. Do not					Approximate
FEMALE:   23b. Was decedent pregnant   1   1   1   1   1   1   1   1   1				Immediate Cause (Final disease or condition			artery	1 dise	asl		Onset and Death
FEMALE:   23b. Was decedent pregnant   1   1   1   1   1   1   1   1   1				resulting in death)	Due to (or a	/	n/ , ha	1640	t and the	dia	
Section   Color   Co			Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a		065114	and a	connay	au.	
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FEMALE:   23d. Date of delivery   23d. Date of deliv	60,	be exician a	a D	resulting in death) Last	Due to (or a	s a consequence of):					
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The part of the control of the contr		the at	ysici	1 ☐Yes 2 ☐No	4 ☐ Pregnant	at time of death				Month	Day Year
24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Vas case referred to medical examiner   25c. Place of Death (Check only one)   25c. Vas case referred to medical examiner	J.	that the		Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner   25c. Place of Death (Check only one)   25c. Vas case referred to medical examiner   25c. Place of Death (Check only one)   25c. Vas case referred to medical examiner	Sign	en sig	ed b		narbie	o alle	sely		1 ☐ Yes	2 No 3 Pro	obably 4 Unknown
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1 Imparient 2 Environment 3 DOA 4 Nursing Home 5 Dotter (Specify)  27. Manner of Death 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 2 Natural 3 Natural 2 Natural	a	n; The ficate r, pagi							1 ☐ Yes 2	12 death? 1No 1 ☐ Yes	2 🗆 No
1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   29a. Certifier   (Check only one)   29a. Certifier   (Check only one)   29a. Certifier   (Check only one)   29a. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)   Abdo, Suzan Dr. 5005 Signal Bell Lane Clarksville, MD 21029   31. Date filed (Mbbtit Day, Year)   32   Signature   32   Signature   33   Signature   34   S		> 0 T		examiner?	Hospital:	tient 2 🗆 FB/Outpat	tient 3 DOA Oth			e 6 □Other (Spec	ih.)
Solution of the composition of t	_ _ 	ng Ph	T:uc	27. Manner of Death	28a. Date of In	jury 28b. Time	of 28c. Injur	ry at 2			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Abdo, Suzan Dr. 5005 Signal Bell Lane Clarksville, MD 21029	<u>≥</u>	after after Direct d in by	ertif		ned building, e	etc. (Specify)	street, lactory, office	1	City or Town, S	itate)	rai Houte Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Abdo, Suzan Dr. 5005 Signal Bell Lane Clarksville, MD 21029		lospits hours uneral	calc	29a. Certifier (Check only Check on Check only Check only Check on Check	Physician: To the besis	at of my knowledge, de	eath occurred at the til	me, date and place,	and due to the caused at the time, date	se(s) and manner as	stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Abdo, Suzan Dr. 5005 Signal Bell Lane Clarksville, MD 21029	0	the H thin 24 the F mplete	Medi	one)							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Abdo, Suzan Dr. 5005 Signal Bell Lane Clarksville, MD 21029  31. Date filed (Mbhth: Day, Year)  32. Registrar's Signature		5 × ≥ 6 §	_	250. Signature and title of certifier	-M		) ET	777		1 -4-1	1119
31 Date filed (Mbhth Day Year) 32 Registrar's Signature			-	30. Name and address of person w	vho completed cause of	death (Item 23a) (Typ	ie, Print)	10 10	1.70		
State 31. Date filed (Mohifi, Day, Year)  Registrar  MAY 2 2 2009  Acade  Acade							ille, MD 21029				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Nesmith 01:50 M Flenry 05 2009 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD Shock enter Baltimore, Trauma If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Days Hours Min. Director So. Carolina 239-64-7579 Jul 11, 1940 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "motical Examinating rough by natified at Director 1 XYes 2 No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2802 Glen Avenue 21215 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ..... any linury or other traumatte event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 □No Specify. 2 Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Northrup Grumman Receiving Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Flossie Nesmith Phillip Nesmith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802 Glen Avenue Baltimore, Maryland 21215 Joan Nesmith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/19/09 Windsor Mill, Md. 4 □ Donation 5 □ Other (Specify) King Memorial Park f Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Brain Injury 10 days Iraumatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Collision Vehi d Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CENTERATION APPROVED BY MEDICAL EXAMINER Examiner Due to for as a consequence of been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn certificate 2**X**No 1 Yes 2 🗆 No 1 □Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural driver Collision 1 ☐ Yes 2 No :16PM 2 Accident vehicle 09 motor 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Pulaski Hwy and Mountain Ko Street within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ZURAIR

MAY 2 2 2009

Bal

and manner stated.

South

Registrar's Signature

wheen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

09-03968 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Lee Pompey, JR. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 18, 2009 Medical Examiner Robert Lee Pompey, Jr 1820 hrs 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Franklin Square Hospital Rosedale **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** If Under 1 Year Foreign 133-82-5806 Director 14 Country) 1 X M 2 9-21-1994 N.Y Usual Residence of Deceden Bnv 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23n or 28a-f show e notified at once, 28a-f shov MD Yes 2 No Essex hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1221 Sugarwood Circle 21221 U S A Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Pages 1 and 2 should be filed within 72 hours after death wit tment of Health and Mental Hygiene.
 rrant: If item 27 is marked other than "natural", or items or other transmitte event, the Medical Examiner must be; Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married White, etc. Yes Widowed Divorced Yes, Give Yea Yes 2X No specify: Black Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ ltimore, MD 21215-0036 8th grade Student School 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Robert L. Pompey, Be Tina L. Potter ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Srather Robert L. Pompey Sugarwood Circle Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department portant: Graceland Cemetery|5-21-2009| Albany, N.Y. Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 Avenue Balto, Ε. North MD 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Hanging Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical ending physician a use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Ectopic pregnancy Month Fetal death Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown signed by the Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 至 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? Yes 2 ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 Y ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 ✔ Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year FOUND: 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: Subject hanged self FOUND: Natural Yes 2 ✔ No Pending hours after death To the Funeral Director: the May 18, 2009 1735 hrs Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 1251 Sugarwood Circle, Essex, MD determined (Specify) Townhouse/Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 19, 2009

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

44111

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD

MAY 92

31. Date filed (Month, Day, Year)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32/Registrar's Signature

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MAY AAL FETERSON 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALD WIN BALDWIN BALTIMERE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Hours 1 □ M 2 🗓 F Days February 16,1931 334-26-2049 **Director** Usual Residence of Decedent 10c. City, Town or Location 10h. County 10a. State 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at Baltimore Baldwin Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 21013 United States 13902 Baldwin Mill Rd. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No
If Yes, Give
Year or Dates Korean War 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) electrical engineer engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gunhild Alice Nyberg Eric George Peterson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any injury or other tra once. Francisca Peterson/wife Baldwin, MD 13902 Baldwin Mill Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem GardMay 24, 2009 Timonium, Maryland

**Physician** /Medical Examiner

attending physician a for use as the burial-

the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

in the past 12 months? 1 ☐ Yes 2 ☐ No

ANE MIA

9 Unknown

1 Yes 2 No

4 Homicide

29a. Certifier

disease or condition resulting in death)

23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

1 - State Registrar

UCHEU	200 E	· Padonia_kd	THIOHEUM, MI	<u> </u>	J93	Г.,
or complications that caused t only one cause on each line	he death. Do not enter the r	mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Deat	n
a. Demen	TIA				Years	
	consequence of):					
b. BARKIASO	V-5				Years	
Due to (or as a	consequence of):					
С						
Due to (or as a	consequence of):					
d						
23c If was outcome	f pregnancy		204	D-16 d-	U. and the control of	

Physician/Medical IF FEMALE: 23b. Was decedent pregnant þ Completed CHKENIC RECURRENT 25. Was case referred to medical Be

Certification: To

Medical

Examine

1 ☐ Live birth 2 ☐ Fetal death Pregnant at time of death a I I Inknown

3 Ectopic pregnancy 5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2009

Month Day

Year 23e. Did tobacco use contribute to the cause of death?

3. Time of Death

8:10

Birthplace (State or Foreign Country)

TIlinois

10d. Inside City Limits

1 ☐ Yes 2X No

 $\mathcal{P}^{\mathsf{M}}$ 

Year

Black, White, etc.

white

2009

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PISPHASIA ORDPHARYN GEAL

John O. Mitchell IV, Funeral Services of Dulaney Valley

2 No 3 Probably 4 Unknown

24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 1 ☐ Yes

UKINARY 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

28c. Injury at Work? 1 ☐Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1) 31295

29d. Date signed (Month, Day, Year) 5/20/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5701 KENWO. D

State Registrar

within 24 hours after death

To the Funeral Director:
completely filled in by the



DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 656 1 - State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Joseph Ρ. Paine May 21 2009 2:05a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fairhaven Sykesville Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Year) 1 ₩ M 2 🗆 F Yrs Maine 90 216-16-8630 2 1918 Aug Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Sykesville 1X□Yes 2□No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7200 Third Avenue C025 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) engineering engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Bodwell Paine Edith K. Partridge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Burghardt Paine (spouse) 7200 Third Ave., CO25, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ី Cremation 3 ☐ Removal from State All County Cremation | 5-22-09 4 □ Donation 5 □ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel (Jargespaig P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final end -(NPD Stage disease or condition resulting in death) Due to (or as a consequence of): Pheumoria Sequentially list conditions, any seeing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 
Yes 2 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2**X** No 1 🗌 Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural
2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

**Examiner** 

MD

Director

Funeral

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Completed

Be

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**Funeral** 

Director

show

ral", or items 23a or 28a-f shore

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Event

Baltimore, Maryland 21215-0036

death with the Maryland

Physician/Medical

ģ

Completed

Be

Certification: To

3 Suicide

29a. Certifier

4 Homicide

The law requires that the death certificate be executed g physician and s the burial-trans Division of Vital Records, P.O. Box 68760 🌣 attending p as been signed by the 2 should be detached has certificate ha Hospital or Attending Physician: filled in by the funeral dir After this e Funeral To the Hosp within 24 ho To the Fune completely f

Medical

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNA SURANTE M.D. 7200 Tourd

determined

29c. License number DOOFGOT

13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

7200 Third Ave, Sykesville, Md 21784

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar's Signature

and manner stated.

		•	For State Registrar	State of Ma	-	epartment of I C <i>ertificate of</i>			giene Reg. No.2	15562
11			Decedent's Name (First, Middle, I	_ast)				2. Date of De	ath	3. Time of Death
	hysicia /Medic		Paul Proctor					Month May 1	.8, 2009 Yea	7:34 AMM
	xamin	-	4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	or Location of Death	1	4c. County of De	ath
			Kensington Nurs	ing & Rehab	. Center		Kensing		Montgor	
	neral		,	Sex 7. Age	(In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da		irthplace (State or Foreign Country)
Dir	ector	-	215-38-6740 Usual Residence of Decedent		71 .	13.		12/3	31/1937 (Un	known)
yland	at ow		10a. State 10b. County		10c. City, Town	or Location	***			10d. Inside City Limits
Mar	a-r sr Ified	cto	MD Montg	omery	Kensi	ngton				1   Yes 2   No
事	e not	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?
ath wi	ust b		3000 McComas Av			20895			United S	
er de	ner m	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	Hispanic Origin? (S ean, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
36 rs aft	, or xamir	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates: U		1 ☐ Yes 2 🗷 No	Specify:		Specify: F	Black
5-0036 72 hours after death with the Maryland	atura cal E	ted	15. Decedent's	Education	16a. [	Decedent's Usual Occu		dia	16b. Kind of Busines	
within 7	Median	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5-		Give kind of work done life. DO NOT use retire	auring most of wor e <b>d</b> )	King	(Unknown	)
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ind be fill tal H	even	a	17. Father's Name (First, Middle, La	st)			<b>.</b> .		, Maiden Surname)	
farylan 2 should be and Menta	natic	္	(Unknown)  19a. Informant's Name/Relationship	(Time Print)	105	Mailing Address (Street	(Unknow		or City or Town State	Zin Code)
Maryland 21215-0036 ad 2 should be filed within 72 hours aff tift and Mental Hygiene.	if tem 27 is marked other tran "natural", or flems 23a of 22a-f show or other traumatic event, the Midical Examiner must be notified at		Nursing Home Fac		K	ensington N 000 McComa	lursing at	nd Rehat	Center n. MD 2089	5-
re, M	other	-	20a. Method of Disposition	esneet	20b. Place of I	Disposition (Name of	i	Date	20c. Location - City	
Pages	ry or		1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe		1	, crematory or other pla my Board	ice)	May 21 2009	Baltimore	, Maryland
Baltimore, permit. Pages 1 ar Department of Hea	any Inju	1	21. Signature of Funeral Service Lic		00382	22. Name and Addre				
<b>a</b> §2.	E # 8		It should be	unam			eral & Cre Ave. Sil		ervices ng, Marylan	d 20910-
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly one cause on each lin	e.					Approximate Interval Between
Phys			Immediate Cause (Final disease or condition	a CHRO	NIC O	BSTRUCT VE HE	IVE PL	ILMON	IARY DIS	Onset and Death
	dical / niner		resulting in death)	Due to (or as a	a consequence of	·):	4 05	-		
	3	-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of	VE HE	AR	TAIL	Uice	
nted	ansit	Examiner	Cause (Disease or injury	`		,				
O,	ial-tra	Exa	that initiated events resulting in death) Last	C Due to (or as a	a consequence of	):				
68760, ficate be executed	pnysician and s the burial-transit	edical		d						
	as th	Med	IF FEMALE:						1	
Box	attending for use as	au/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome <sub>I</sub> 1 ☐Live birth	2 Fetal death	3 □Ectopic pregnanc	гу		23d. Date of o	delivery Day Year
O	thed f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (specify)_				- 1,
ecords, P.O. Box law requires that the death cert	should be detached		Part II. Other significant conditions	s contributing to death bu	it not resulting in t	the underlying cause gi	ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ds	ld be	d by						1 🗆	Yes 217 No 3□	Probably 4 ☐Unknown
CO W	shou	lete						24a. Was	an 24b. Were	autopsy findings available
The la	page 2	Completed							psy prior t ormed? death 2 ∰No 1 □ Y	
	ector, pag		25. Was case referred to medical				26. Place of Dea			es 2 <u>12</u> 7N0
Vision or Vita Attending Physician:	ral director,	20	examiner? 1 ☐ Yes 24⊅ No	Hospital: 1 ☐ Inpatie	nt 2□ER/Outp	oatient 3 DOA	her: 4 <b>₽</b> Ñursing F	lome 5□Res	idence 6 □Other (S	pecify)
E 6 4	la el		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		ury Wa		28d. Describe	how injury occurred	
SiO Sicher	the fu	cati	2 Accident investigat 3 Suicide 6 Could not	he			]Yes 2□No	00(1 1)	(0)	B 18 1 1 1
Division To the Hospital or Attending within 24 hours after death.	in by	Certification:	4 Homicide determine		:. (Specify)	n, street, factory, office		City or To	Street and Number or wn, State)	Hurai Houte Number,
spltal ours a	illed		29a, Certifier 1 Certifying	Physiclan: To the best of	of my knowledge,	death occurred at the t	ime, date and place	e, and due to the	cause(s) and manner	as stated.
e Ho:	erun	edical		aminer: On the basis of and manner sta	examination and					
Vithir th	dwoo	Me	29b. Signature and title of certifier			29c. Licen			29d. Date signed (Mo	onth, Day, Year)
				wand!	040	000	5712	4	50	0109
			30. Name and address of person wh	o completed cause of de	eath (Item 23a) (T	ype, Print) Dr., #206;	Rockwi 11	o MTh	20850	
4			Truong Bao M.D.			DI., 1/200;	MOCKVIII	.e, m	20000	
В	Sta legistr	r.C	31. Date filed (Month, Day, Year)		ır's Signature	,				
DHMH 17			MAY 2 2 20	19 Lener	1. 19	acked				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3rd 2009 5:00 AM **Physician** May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown andallstown Genesis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | Min. | Min. | May 31 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Maryland 214-64-613 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 4911 Challedon Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2☐ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ MNo Specify: Black Yes, Give Year or Dates: þ 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental and Mental Lora Thaxton James Thaxton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2::
Department of Health a:
Important: If item 27 Is
any injury or other trau 4911 Challedon Road Baltimore, Maryland 21207 Brittany Pitts 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Catonsville, Maryland 05/12/09 Metro Crematory, Inc. 5 ☐ Other (Specify) 4 ∏Donatio 22. Name and Address of Facility 21. Signature of Juneral Service Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or ..... lications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death To not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) AID ears **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 🗷 No for 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy page performed? MOXIC 2 X No certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Medical Certification: To Be examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0058965 4th Sama 2009 Mau Choma 30. Name and address of person who completed cause of (eath (Item 23a) (Type, Print) Liberty Road KHANAJA , M.D Randallstonk

State

Registrar

31. Date filed (Month, Day, Year) MAY 2 2 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:40 p M Myrtle A. Price May 16, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore 3606 Woodlea Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 F Maryland Director Mar 9, 1929 80 220-20-2465 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1∩a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No Director Baltimore N/A Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21214 U.S.A. 3606 Woodlea Avenue Funeral permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or incorporate. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 □No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify Black \$ 3 ★Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Johnson Farl Johnson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3606 Woodlea Avenue Baltimore, Maryland 21214 Steven Price 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md. 05/22/09 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 110 23a. Part 1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, opheart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 90 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Exami and burial-tran Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicompleity filled in by the funeral director, page 2 should be detached for use as the Londoniety filled in by the funeral director, page 2 should be detached for use as the Londoniety filled. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No P.0. 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation **Z** ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Render

State Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

12109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kacien

Loch

Year

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16565 Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 0415AM Dora 2009 05 14 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Harbor Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Hours Months Days 1 ☐ M 2 🕱 F 85 220 14 2119 Michigan 04/17/1924 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 TYPes 2 □ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2702 Norland Road 21230 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Riveter Coast Guard 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Montz Lillian Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Hernandez / Daughter 2702 Norland Road Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD. State Veteran Cem. 05/19/2009 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Auneral Service

**Physician** /Medical

attending physician for use as the buria

cate has been signed by the page 2 should be detached

certificate

ours after death.

eral Director: After this certific filled in by the funeral director,

24 hours

within 24 ho To the Fune completely f the

Physician/Medical

2

Completed

Be

Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Ne dical Examiner must be notified at

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

10a, State

Director

by Funeral

Completed

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**Funeral** 

Director

Examiner Examiner and burial-trai

4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiorespiratory Due to (or as a consequence of): Bilateral Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify)

Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 🗷 No 1 ∐Yes 2 ∐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 05-14-2009

Baltimore, MD 21285

30. Name and address of person who completer cause of death (Item 23a) (Type, Print

XIAOBING South Hanover St. V U MD 3001

State Registrar 31. Date filed (Month, Day, Year) MAY 22 2009 32. Registrar's Signature

Funeral Director

ViRGINIa

AFFERTY

Baltimore, Maryland 21215-0036

		Pleas	se Type or	Print in	Black II	ndelible	e Ink	. Ensure	All	Copies	Are Leg	jible.	
	. For		State of	of Marylar	nd / Dep	artmer	nt of F	Health and	d Me	ental Hyg	iene		
	= State Registrar				Ce	ertificat	e of	Death		R	Reg. No. 2009 1655		
	1. Decedent's Name	e (First, Middle,	Last)			2. Date of Deal Month					Day Vees		
an :ai	Virginia	Emma Ra	afferty							3	,	2009	1210 PM
er	4a. Facility Name (II	f not institution,	give street and nu	mber)		4b. City,	Town, o	r Location of De	eath		4c. Cour	nty of Dea	th
	FRANKLI	n Squ	areHos	PITAL C	enTer	^ 4	205	edule	2		Bal	Tin	100 2
	5. Social Security No		last birthday		r 1 Year Days	If Under 24 H	Hrs. 8	B. Date of Birth (Month, Day)	Year)	9. Bir	rthplace (State or Foreign ountry)		
	217 16 88	Yrs.	III o i i i i i	Duyo	110010		July 11,		Mar	ryĺand			
	Usual Residence of	Decedent											
	10a. State	10b. County	10c. C	ity, Town or l	cocation							10d. Inside City Limits	
Funeral Director	Maryland Baltimore Middle						r						1 □Yes 2 No
ire	10e. Street and Nun	nber				10f. Zip	Code			1	0g. Citizen o	f What Co	ountry?
alD	13212 Pat	uxent I	₹d.				2122	20					
ne	11. Marital Status		12. Was Dec	edent Ever in U	I.S. 13	. Was Dece	dent of F	lispanic Origin? an, Mexican, Pu	? (Spec	cify Yes or No-		ace - Ame	erican Indian,
	1 Never Marri	ed 2□ Marrie		2 X No		1 🗆 Yes	,	Specify:	0011011	iouri, oto.,			nite
by	3 X Widowed	4 Divorced		I LLITES	2 30 140	эреспу.			Spec	ony: VVI	II CE		
Completed	(Spec	16a. Dec	edent's Usu ve kind of wo	al Occup ork done	pation during most of s d)	working	9	16b. Kind of	Business	/Industry			
Elementary/Secondary (0-12) College (1-4or 5+)						_		d)			Oran Li	[cmc	
o  /						omemak	'GT				Own Home		
Be (	17. Father's Name (	First, Middle, L	ast)			18. Mother's Name (First, Middle, Maiden Surname)							
Albert C. Rauck								Emma F	Rose	e Reime	r		

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park 5/26/2009

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

20c. Location - City or Town, State

Elkridge, Maryland

Month

1 ☐Yes 2 ☐ No

Approximate Interval Between Onset and Death

years

Year

7 405

8336 Bradshaw Rd. Kingsville, Maryland 21087

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is merked other then "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evansine must be multiled a once.

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature/of Funeral Service Licensee

20a. Method of Disposition

Lawrence H. Rafferty Jr. (Son)

1 Burial 2 Cremation 3 Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

SheTT

Safal 31. Date filed (Month, Day, Wear)

**Physician** /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director. After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, of

Examine Physician/Medical Be Completed by Medical Certification: To

22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SysTem organ multi disease or condition resulting in death) Due to (or as a consequence of): Coran ary Artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Vascular Disease Peripheral
Due to (or as a consequence of): IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 - No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5-21-09 RESODOO M.P.

State Registrar

DHMH 17 Rev 1/2001

9000 FRANKLIN Square PR Balto Md 21237

EDWARD REINISCH

	Physici	an	1. Decedent's Name (First, Middle, Last					Mon	of Death th	Day Y	'ear	3. Time o	of Death
90	/Medic	al	Edward L.			1		May	15	2009		5,6	150 M
	Examin	er	4a. Facility Name (If not institution, give Stella MAris H			4b. City, Town,	or Location o	t Death		4c. County of Balti		^_	•
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)			24 Hrs. 8. Date	of Birth				or Foreign
	Director		217-46-0026	<b>x</b> <sup>M 2□ F</sup> 6	3 Yrs.	Months Days	Hours	Min. Dec	ith, Pay, Ye	1945	Coun	MD MD	
	De ,		Usual Residence of Decedent										
	arylaı <b>show</b>	7	MD Baltim		. City, Town or Lo	ndalk					1	0d. Inside 0	Sity Limits s 2 🔀 No
	he M	ectc	10e. Street and Number	016	- Du				10-	Citizen of 14th	-4.0		, 22140
	with t	<u>o</u>	9 Wells Avenue			10f. Zip Code	222			10g. Citizen of What Country? USA			
	ns 23	by Funeral Director	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of If Yes, specify Cu		gin? (Specify Yes		14. Race -	- Americ	an Indian,	
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No				, Puerto Rican, et	tc.)		White, 6		
200	iral",	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:								Specify:	wn:	ıte	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, its fixeden Exa, it are must be malled at	Completed	15. Decedent's Edu (Specify only highest grad	cation 'e completed)	i (Give	dent's Usual Occ	e during most	of working	16	16b. Kind of Business/Industry			
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0	should be filed and Mental Hygi marked other imatic event, I	BeC	11 th 17. Father's Name (First, Middle, Last)				Aiddle, Mai	den Surname)	1				
<u>a</u>	uld be Venta rked tic ev	일	William Reini	sch			Ca	atherin	e Ro	ofing			
a Z	short and fisma is ma		19a. Informant's Name/Relationship (7)	' . '		ng Address (Stree							
≥,	and and m 27	13	Gale Reinisch			Wells A							
Baltimore, Maryland	ges 1 If of H If Itel		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Removal from State	b. Place of Dispo cemetery, crei Bayview	osition (Name of matory or other p	ace)	Date		c.Location-Ci altimo	-		
	it. Pa rtmer rtant: njury		4 □ Dopal on 5 □ Other (Specify)						Ь	altimo	or e	MD	
g	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic es once.		21. Signature of Fineral Service Licens	30/10		2. Name and Add		300 M		Ave. E			
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only o	ication is that caused the d		Connel ter the mode of d					sex	Approxima	ate
	Physician		Immediate Cause (Final	2					•			Interval Be Onset and	
1	/Medical		disease or condition resulting in death)	a. LUNG CANCE									
	Examiner		Sequentially list conditions	b									
_	ed sit	Examiner	if any, leading to immediate	Due to (or as a con	sequence of):								
	and and I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a con	sequence of):						_  -		
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Box 68/60,	death certificate be executed e attending physician and d for use as the burial-transit	ician/Medical		3							-		
ŏ	n cert	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		ne 10770-00				23d. Date	of defive	ery	
	deat e att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		☐ Ectopic pregna ☐ Other (specify)				Mont	h	Day	Year
7. O	w requires that the de been signed by the should be detached	Physi	9 Unknown					00-	Didash				4
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<u>ra</u>	ificate or, pay	ပ္သ	25. Was case referred to medical				00 Pl		performe Yes 2	No 1 E		2 🗆 No	
>	Physician: r this certific ral director, p	To Be	examiner?	Hospital: 1 □ Inpatient 2	2 ER/Outpatie	nt 3 TIDOA C	ther:	of Death (Check irsing Home 5		e 6 <b>▼</b> lOther	(Specif	W HOSI	PTCF
	ding Physician: The I h. After this certificate ha funeral director, page	T:ű	27. Manner of Death	28a. Date of Injury (Month, Day, Yea	28b. Time o	of 28c. In				injury occurred	• •	<i>y</i> ) 11051	. TOE
Š		atic	1 Natural 5 Pending 2 Accident investigation	(month, buy, rea	a) injury		□Yes 2□	No					
	- e - c	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str pec <i>ify)</i>	reet, factory, office	9	28f. Loca City	ation (Street or Town, S	et and Number State)	or Rura	al Route Nu	mber,
	urs all urs al		On Continu							-,,			
Ì	To the Hospital or within 24 hours after To the Funeral DII completely filled in	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam one X Nurse Pract:	rsician: To the best of my iner: On the basis of exar	клоwledge, deat mination and/or ir	in occurred at the nvestigation, in m	time, date ar y opinion, dea	nd place, and due oth occurred at the	to the cau e time, date	se(s) and man e and place, an	ner as s nd due to	stated. o the cause	(s)
1	Fo the vithin Fo the comple	Mec	29b. Signature and title of certifier	LLICHET Stated.		29c. Lice	nse number		29d	. Date şigned (	(Month,	Day, Year)	
•	~ > F 0		· //×	10-	N	RIA	(y) C	9		5/18	109		
			30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type,	Print)		/		01101	0		
			MARIAM BAKIR, CRN		ANEY VAL	LEY RD.	TIMON	IUM, MD	2109	3			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature bark			-					
	Registr	ar	MAY 2 2 2009	( Masser C	i. Dave								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State o	f Maryland		artmen rtificate			and M	lental Hy	/giene Reg. No.	Z 11111	9	16568
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	Day	Yea		3. Time of Death
-	/Medic	cal	Helen		Ruby		I			<b>15</b>	May 1		009		1:00 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, Gilchrist Ce	give street and nui nter	mber)			Town, or DWSO	Location o	of Death		4c.	County of De Balti		^
	Funeral			6. Sex	7. Age (In yrs. la:	st birthday)	If Under	1 Year	If Under		8. Date of Bi	rth	9. B	irthplac	e (State or Foreign
	Director		220-03-2517	1□M 2√F	89	Yrs.	Months	Days	Hours	Min.	Mar 2	3, <sup>rear)</sup>	20 Ma	Country <b>3 ° y 1</b>	and
	pui 🔏		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation							104	Inside City Limits
	f sho	ō		timore	Too. Oity,	Tow								1.00	1 □ Yes 2 □ No
	the N	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What (	Country	
	3a ol		931 Ellendale	Drive				2128	6				U.S.A.		
	death	Funeral	11. Marital Status		edent Ever in U.S.	. 13.				igin? (Sp	ecify Yes or N Rican, etc.)		14. Race - Ar Black, Wh	nerican	
36	or ite		1 ☐ Never Married 2 ☐ Marrie	ed 1 ∐Yes If Yes, Gi	2 <b>∑X</b> No ve		1 ☐Yes 2		Specify:		i nodin oto.,		0		
5-0036	hours ural",	d by	3 XWidowed 4 ☐ Divorced	Year or D	ates:				ation				nd of Busines	√hit	
-5	n 72 "nat	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usua kind of wor DO NOT us	il Occupi k done c e retired	ation <i>furing mos</i> '}	t of work	ing	10D. KII	na or busines	ss/maus	шу
2121	withi	E O	Elementary/Secondary (0-12)	College (1	I-4or 5+)		memake		,				Own h	ome	
β	al Hyg othe	Be C	17. Father's Name (First, Middle, L	ast)	•	-			18. Mothe	er's Nam	e (First, Middle	e, Maiden	Surname)		
<u>a</u>	Menta Menta arked atic e	10	Frank	Ada	amczyk				ΑΑ	lice	<u> </u>		Two	lsky	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "modeal Evanther must be notified at		19a. Informant's Name/Relationsh				-				al Route Numi			e, Zip Co	ode)
<u>د</u> ده	and Health Im 27		Michelle Schra	ml-daughi							WSON,		21286 cation - City	or Tour	State
٥٢	iges 1 nt of h if ite or of		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		State State	metery, crei	osition (Nan matory or of Valle	her plac	e)		21/09	1	non i um ,		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		4 □ Donation 5 □ Other (Sp		ļ ļ	-		-	1			1	-		
Ba	Deperment of the series of the		21. Signature of Funeral Service L	WILL	iam G. Da	au   -	1050	Yor	k Rd.	"Ruc , To	wson,	on Fu MD 2	neral 1204	Hom	e, Inc.
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that conly one cause on e	each line.	Do not en		e of dyin	g, such as	cardiac	or respiratory	arrest,		- In	pproximate iterval Between nset and Death
7	/Medical Examiner		resulting in death)	ue to	(or as a conseque	ence of):					روي	727	A.	C	larys
-0	P #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	D. Due to	(or as a conseque				Ν.	1R TO	0.1	) do	$\overline{\mathcal{O}}$	Y	ners
130	ate be executed hysician and he burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Per	or as a conseque		rea	20	Pil	1/	The Pin	1101		_	
8760,	be exician burial		, , , , , , , , , , , , , , , , , , ,	Due to	(or as a conseque	ance oi).			ز ادار	P	1.1.	ien.			
587	ficate phys s the	gic		d						X7_`	541,				
Box 68	eath certific attending p for use as	Me.	IF FEMALE: 23b. Was decedent pregnant		tcome of <u>p</u> regnan				1/	list	. /		23d. Date of	delivery	
O. Be	the Hospital or Attending Physician: The law requires that the death certific hin 24 hours after death.  The Funear Director: After this certificate has been signed by the attending p mpletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 ☐ Fetal on nant at time of de nown		☐ Ectopic p ☐ Other (sp						Month	Da	
σ.	s that ned b	by Ph	Part II. Other significant condition	s contributing to d	eath but not result	ting in the u	inderlying ca	ause give	en in Part I	i.	23e. Did	tobacco u	se contribute	to the	cause of death?
rds	quires t										1 🗆	Yes 🏂	<b>3</b> No 3□	Probab	oly 4 🗌 Unknown
တ္ထ	aw requir as been si 2 should I	olete									24a. Wa		24b. Were	autops	y findings available
e e	The I	Completed									peri	opsy formed? 2 ⊠No	death	?	letion of cause of □No
Vital Records,	<b>hysician;</b> The Is his certificate ha I director, page 2	Be C	25. Was case referred to medical examiner?						26. Place	e of Deat	h (Check only				
of V	Physic this o	ျ	1 res 2 □ No		Inpatient 2 ☐ E			_	4 ∐ N	ursing Ho	ome 5 Res			pecify	respure
u C	ding Ph n. After th funeral	Certification:	27. Manner of Death 1 □ Natural 5 □ Pending		th, Day, Year)	28b. Time o	-	8c. Injur Work			28d. Describe	how injury	y occurred		
isi	ttenc death stor: / the i	icat	2 Accident investigation inve	ot be	of Injury - At hon	0300		1 🗆	Yes 2	INO	28f Location	(Street an	d Number or	Rural F	Route Number,
Division	al or Attendis after death. I Director: A d in by the fu	ertif	4 Homicide determine	ned buildi	ing, etc. (Specify)	0.5	root, raotory	Onico			City or To	wn, State	), , _		bouch MD
	To the Hospital or within 24 hours after To the Funeral Directory (Completely filled in b			Physician: To the	best of my know	ledge, dea						e cause(s)	) and manner		
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical E	xaminer: On the b and man	ner stated.	on and/or if	nvestigation	, in my o	pinion, de	ath occu	rred at the time	e, date and	place, and c	due to tr	ne cause(s)
	Vithi Com	Σ	29b. Signature and title of certifier	/ ~			290	Licens	e number	) 1	,	29d. Dat	te signed (Mo	onth, Da	iy, Year)
			your	Mis)				ソ	>83	503	5	wa	7 18	00	7
	10		30. Name and address of person v	ho completed caus	se of death (Item	23a) (Type,	Print) 67	01	∕√ <sup>c</sup>	CI	rovces	ST	700	501	N MO
	Sta Registr		31. Date filed (Month, Day, Year)	2 2009 32. 5	Registrar's Signatu	Jre /	base								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4b, perPHYS, G891, 5722709, WS
State of Maryland, Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** E. SWITZER 8:40KM 3009 /Medical 4b. City Town, or Location of Death
Baltimore County of Death 4a. Facility Name (If not institution, give street and number, Examiner HUSPITAL CENTER HARBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT 10, 1936 Birthplace Country) PA Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F Months Days Hours Yrs. 185.30.9333 1936 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director GLEN BURNIE ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 101 FURNLEA DR. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No NYes, Give Year or Dates:1952-74 Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2XXNo þ Specify. 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene.
em 27 is marked other than
ther traumatic event, the M 12 STAFF SARGENT US ARMY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ္ရ ALFRED PAUL SWITZER MARCELLA CHRISTINA DUNKEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. WIFE FURNLEA DR. GLEN BURNIE, MD 21060 SARAH SWITZER 101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MDVETCEM CRQWNSVILLE 5.13.2009 4 Dopation 5 Other (Specific CROWNSVILLE, MD 22 Name and Address of Facility
NK FUNERAL HOME P.A ure of Functal Service GREGORY M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 rollications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease shock or heart failure Immediate suse (Final disease or condition resulting in de CONGESTI **Physician** /Medical Due to (or as a consequence of): Examiner 21010 pc4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician a Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury - (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 PALTIMO 0 31. Date filed (Month, Day, Year) 30 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** MARIE HARRIETT SNYDER 15, 9:20 A M May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Med Ctr Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Pay, Year) 07/04/1922 Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 □ M 2 🗹 F Months Days Hours 213**-14-**5193 86 **Director** Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 ☐Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or 8458 Church Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Š Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any filpury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Edward Rapp Mary Josephine Deffendell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Snyder/Husband 8458 Church Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem 05/19/09 Crownsville, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Artherosclerotic Cardiovascular Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ☑No 1 ☐ Yes 2 🗹 No of Vital 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not b 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office ulding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medicai r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D25782 05/15/2009 neted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp Stephan Izzi, 7575 Ritchie Highway, Glen Burnie, MD 21061 State

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Saunders Jr Oakley Henry 05 19 2009 1:00a. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3505 Springdale Ave Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. **№** M 2□F Months Hours Days 81 212-22-4246 Director 09 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ▼Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U • S • A • Race - American Indian, Black, White, etc. 3505 Springdale Ave 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 ☐ If Hes, Give Year or Dates: 1 ☐ Never Married ♣ Married 2 No o. 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglene Important: If item 27 is marked other the any Injury or other traumatic event, the once. 12th grade Private Practice 4yrs Pediatrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oakley H. Saunders Sr. <u>Mary Booker</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Barbara Saunders-Wife</u> <u>3505 Springdale Ave, Baltimore, Md 21215</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet 5/27/09 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, M 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLON CANCER METASTATIC **Physician** YEARS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2XNo 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate har ral director, page performed? 1 Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. peen has or Attending Physician: Funeral Director afer

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 h To the Fu

Hospital

the

31. Date filed (Month, Day, Year)

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier nidu 29c. License number

1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

> chathins 0066 034

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

05-19-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401

Mathias HOLDHOFF, M.D. BLIT

determined

North Broadway BALTIMORE, Mg

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19 MAY 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA CANTON PALTIMORE 9. Birthplace (State or Foreign Country)
S. CAROLINA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Min Days 1**⊠**M 2□ F 247-24-4276 JUNE 8, 1923 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or or other traumatic event, the Medical Examinar must be retified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1⊠Yes 2□No Funeral Director BALTIMORE MARYLAKID 10g. Citizen of What Country? 10e. Street and Number 400 MILLINGTON AVE., APT. 22 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: BLACK Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION WORKER CONSTRUCTION COMPANY 9TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RENNETT SINCLAIR ELLIOTT ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ST., BALTIMORE, MD 212 DOUGLAS (DAUGHTER) 4020 WALRAD SHIRLEY Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND NATIONAL COM 05/24/2009 LAUREL, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M JR. FUNERAL JOSEPH H. BROWN JK. FUNERIL 1821/10 212/1 Muamo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final aller Physician disease or condition resulting in death) /Medical Due to (or as a consumence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. the nding puse as IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) P.O. I 1 □Yes 2 □No q | Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Xes 3 Probably 4 ☐ Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Z 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of eath Natura 5 Pending investigation 1 ☐ Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and D0062194 of person who completed cause of death (Item 23a) (Type, Print) 301 ST 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 2 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Frank L. Saville, Jr. May 14,2009 8:13P 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, January 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Months Days Hours Min. 1 M 2 □ F West Virginia 68 Yrs 213-38-8252 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐Yes 2 ▼No Parkville Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 2613 Joppa Terrace 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 62 1 966 1 Yes, Sive 1962 1 966 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married White Specify 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RCA Chief Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Hough Frank L. Saville, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2613 Joppa Terrace Parkville, Md. 21234 Nancy Saville 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State White Hall, Md. 4 ☐ Donation 5 ☐ Other (Specify) 5-18-2009 Wiseburg Cemetery 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Sunere Service Lice 9705 Belair Rd. Nottingham, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ROSTATE VICEN'S disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) W 1/14 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show

Pages 1 and 2 s ment of Health ar

other

Department of Important: If it any Injury or conce.

Maryland 21215-0036

Baltimore,

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7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Experience must be notified at

**ledical Examiner** 

attending physician and for use as the burial-tran

The law requires that the death certificate be executed 68760 s been signed by the should be detached Records, Division eral Director: ō

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1 Natural

2 Accident

4 ☐ Homicide

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier (Check only one)

Certifi To the Hospital o

> State Registrar

31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 ☐ Could not be

determined

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** May 2009 1:30 A 20 Summerville Priscilla /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Long Green Center Baltimore 8. Date of Birth (Month, Day, Year) 01/01/1911 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 TF Yrs. Maryland 98 **Director** 214-22-2446 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Exprime Trust be notified at X Yes 2 No Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21215 U.S.A. 5124 Chalgrove Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: <u>م</u> 3 ₩Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Thomas 2 Robert Briscoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tanya Brown/Granddaughter 5124 Chalgrove Ave., Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Mg Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 05/29/2009 Baltimore, Maryland Arbutus Mem. Park 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARNIOVASCULAR UEARS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of) attending physician for use as the burial Box 68760, þe Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been siç page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 110 1 ☐ Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28c. Injury at After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD, BATIMORE, MI) 21236 LACE, un) 9005 WAL 32. Registrar Signature 31. Date filed (Month, Day, Year) State 2 2 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:30 A. M **Physician** Frank Joseph Samay May 17, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford County Bel Air Upper Chesapeake Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | NOV | 12, 5. Social Security Number 199-26-7822 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 74 Tarentum, PA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State if flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I'm Medical Exartinat near out the modified at Forest Hill Maryland Harford Co. 1 ☐ Yes 2 ☐XNo Director 10e. Street and Number
111 Sunshine Court, Unit F 10g. Citizen of What Country? 10f. Zip Code 21050 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married XXMarried 1 □Yes 2 No Specify; White Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry
Federal Government Dept. of Agriculture Elementary/Secondary (0-12) College (1-4or 5+) Information Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Plochan Frank Samai ပ္ 19a. Informant's Name/Relationship (Type. Print) (Wife) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 111 Sunshine Court, UnitF. Forest Hill, Maryland 21050 Pages 1 and 2 Department of Healt Important: If Item 2 any Injury or other more, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 20, 2009 Forest Hill, Maryland Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myo cardiac In **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 2 No 3 Probably 4 Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **2** No 1 ☐Yes 2 ☐No 1 ☐ Yes Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chisapeakepr, Bel. Basu 32. Registrar 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 18, Day 200 year May 10:22pm 4c. County of Death 4b. City, Town, or Location of Death White MArsh Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 12,1917 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days 1 StM 2 □ F 91 MD 10d. Inside City Limits 10b. County

1 ☐ Yes 2 No

Approximate Interval Between Onset and Death

Year

4 Unknown

Day

2 🗆 No

20,2009

1 Tyes

**Physician** Leo G. Szeliga /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 11124 Bird River Grove Road 5. Social Security Number **Funeral** 213-07-2696 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location show MD Baltimore Director White MArsh 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11124 Bird River Grove Road 21162 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1¥7Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Beth Steel 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Szeliga Josephine Cholewinski ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Szeliga / son 3997 Farm Lane Monrovia MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 5/20/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 MAce Ave, Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition gastric **Physician** adeno carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cate has been si 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Attending 1X Natural 5 Pending death. 4 hours after death.

4 hours after death.

5 uneral Director: A
ely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Griene St Baltimore SHARUN BALANSON

State Registrar

31. Date filed (Month, Day, Year)

MAY 22 2009

32/Registrar's Signature

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State Registrar 30. Name and address

Syan

31. Date filed (Month, Day, Year)

of person w

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o completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

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CENEST BALLIMORE, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 0235 AM may 8 MAJOR 2009 LEE 36071 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner altemore Care Center Balton If Under 24 Hrs. Rehabilibles Extended 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 3ex 1 M 2 □ F **Funeral** Months Days Hours 254-80-328 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Yes 2□No ir than "natural", or items 23a or 28a-f shoi the Medical Evantimer is ust be notified at by Funeral Director 10g. Citizen of What Country? 10e. Street and Number. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Iffres. Give 11. Marital Status Pages 1 and 2 should be filed within 72 hours after Never Married 2 ☐ Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Yes, Give ear or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. 7 is marked other traumatic event, 17. Father's Name (First, Middle, Be ပ Department of Health an Important: If item 27 is any injury or other trau once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Dik to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 2 No 1 ☐Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 | Homicide [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rehab, liha

29c. License numbe

052739

3600 LUCK ROWEN

29d. Date signed (Month, Day, Year)

			For	State of N	/laryland		rtment of H		Mental Hy	giene	16570
			Stete Registrar			Cer	tificate of L	<i>Death</i>	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, La Kathryn Mae Spit	_					May 21	, 2009 Year	7:15A M
)	/Medic Examin		4a. Fecility Name (If not institution, giv	e street and numbe	r)		4b. City, Town, or	Location of Dea	th	4c. County of Dea	th
			Season's Hospice		Age (In yrs. la:	et hirthday)	Ra If Under 1 Year	if Under 24 Hrs		Balt:	imore tholace (State or Foreign
П	Funeral Director		5. Social Security Number 6. S 216-30-5155	M 2XF	77	Yrs.	Months Days	Hours Min	. (Month, Da		thplace (State or Foreign ountry) aryland
	ס		Usual Residence of Decedent		100 City	Town or Lo	antian				10d. Inside City Limits
	show	5	10a. State 10b. County		Toc. City,	TOWIT OF EO					1 ☐ Yes 2 ☐ No
	the N	rect	MD Balti 10e. Street and Number	more			10f. Zip Code	allstown	1	10g. Citizen of What C	ountry?
	th with 23a or	Funeral Director	3801 Schnaper Dr	ive, Apt.	411		211			United Sta	
	tems tems	uner	11. Marital Status	12. Was Deceder Armed Force	s?	. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? ( n, Mexican, Pue	Specify Yes or No irto Rican, etc.)	- 14. Race - Am Black, Whi	
39	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. An Hygiene. I de Hygiene. I de Chter than "natural", or items 23a or 28e-f show other than "natural", or items 20a or 28e-f show event, I.p. Medical Examiner must be notified.	by F	1 ☐ Never Married 2万 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2€ If Yes, Give 2 Year or Date:	ζ s:		1□Yes 2X No	Specify:		Specify:	White
21215-0036	72 hou	sted	15. Decedent's E (Specify only highest gr.		ĺ	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of w	orking	16b. Kind of Business	
121	- 00	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		ossing Gu	_			re County Department
d 2	Hygie Hygie other		17. Father's Name (First, Middle, Last	)	1,	OL.	0551116 00	18. Mother's Na		Maiden Sumame)	bepar smerrs
/lan	should be filed withir nd Mental Hygiene. marked other than imatic event, the M	To Be	Samuel Leslie H	oole					stal Ali		
Maryland	2 a a		19a. Informant's Name/Relationship	_						er, City or Town, State,	
45	s 1 and 2 of Health Item 27		Herbert Spittel - 20a. Method of Disposition	Husband	20b. Pla	ice of Dispo	sition (Name of	1	Date 411	, Randalls 20c. Location - City o	r Town, State
D III	Pages ent of nt: If II	1	Burial 2 Cremation 3 C 4 Donation 5 Other (Speci		te MD °	Peters	ms cemete ville	ery 5-2	26-2009	Crownsvil	le, Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If Ite eny injury or ott	/	21. Sign-tur of Rineral Service Lice	nsee	1	1/2	Name and Addres	ss of FaciliAmb	rose Fun	eral Home,	Inc.
_	89 E 29		23a Part1. Enter the disease, or con	2101	2/1/2					Arbutus, M	Approximate
	<b>.</b>		shock, or heart failure. List only Immediate Cause (Final	one cause on each	n line.	,		g, sasir as sara.	ao o. 100pa.o., a		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		as a conseque		nentia				months
	Examiner		Sequentially list conditions,	b		13 E 2 (14)					
	ted nsit	nlner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	DUB TO (OF	as a consoqu	arina otji					
DP.	te be executed ysician and te burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ence of):					
37605	icate be executed physician and s the burial-transit	cal		d							
x 68	entifica ding pl	/Med	IF FEMALE:	23c. If yes, outcome	me of pregnar	ncv			·	23d. Date of d	elivery
Вох	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 4□Pregnan	n 2 ☐ Fetal t at time of de	death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	<u> </u>		Month	Day Year
P.O.	at the c by the stached	hys	9 Unknown	9□ Unknow					One Did	tobacco use contribute	to the cause of death?
	w requires that been signed t should be det	þ	Part II. Other significent conditions	contributing to deat	h but not resu	Iting in the u	inderlying cause giv	en in Part I.			Probably 4 Unknown
Records,	v requi	Completed							24a. Was		autopsy findings available
Re	The lay	dwo							auto perfe	ormed? death'	completion of cause of es 2 No
Vital		BeC	25. Was case referred to medical examiner?						eath (Check only	one) I	putrent
of V	Physician: this certificanal director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2 1	ER/Outpatie		4 L Nuising	-	idence 6 Other (Sp.	pecity) hospice
ono	fter	tlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	Wor	k? Yes 2 □ No			
Division of	Attending or death. ector: After by the fune	Ilfica	3 Suicide 6 Could not determine	289. Place of	Injury - At ho , etc. (Specify	me, farm, st	reet, factory, office			(Street and Number or own, State)	Rural Route Number,
Ö	itel or irs after rel Dir iled in	Cerl							and due to the	anuna(a) and manner	ac etated
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	edical Certification;	Charleson DI Madient Cue	and a de a Company	a of avaminat	ion and/or i	wastingtion in my /	oninion death or	ecurred at the time	cause(s) and manner , date and place, and d	ue to the causets
	within To the	Me	29b. Signature and title of certifier		/	24 1	29c. Licens	se number	1.1	29d. Date signed (Mo	nth, Day, Year)
			Dlogge	~			1	3387	7	May 2	1 2009
	12		30. Name and address of person who	completed cause	of death (Item	23a) (Type	, Print) Rd Suit	£ 108 1	Kandallst	OW. INUS	21133
		ate	31. Date liled (Month, Day, Year)	32. 500	gistrar's Signal	ture).	barker	,		29d. Date signed (Mo May 2 own: MO	
	Regist		MAY 22	2009 /	record	1. 1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** John Herschell Taylor Jr. 5:30 p 2009 May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Stella Maris Hospice Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/20/1936 (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 224-38-8966 **№** М 2 П Р 73 VA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. Count show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Gwynn Oak MD Baltimore 1 DXes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3511 Flannery Lane 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ₹ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Construction 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) Be John Herschell Taylor Margaret King ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3511 Flannery Lane, Gwyn Oak, MD 21207 Rosella Taylor / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Crematory 5/22/2009 Hanover , MD 4 Donation 5 Dother (Specify) Marshall 12. Name and Address of Eacility
Maryland Cremation Services 21. Signature of Funeral Service Licensee DOTO ta Mousial. PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown ils certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Hospital: Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) HOSPICE 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 the Hospital or Attending 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

rse Practitioner stated.

29c, License number 29d. Date signed (Month, Day, Year) 29a. Certifier (Check only one X Nurse 29b. Signature and title O cause of death (Item 23a) (Type, Print) 30. Name and add MARIAM BAKER, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Sigrature State Registrar

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 0510AM Clarice C. Thornton 2009 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Agnes Itimore hosDil If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth 5. Social Security Number **Funeral** Months Hours Min. (Month, Day, Year) Sep 20, 1939 Days 1 □ M 🙀 🗆 F Maryland Director 69 218-36-4376 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State "natural", or items 23a or 28a-f show X 1 □Yes 2 □ No Baltimore Director **Baltimore** Maryland . and 2 should be filed within 72 hours after death with the N Health and Mental Hygiene.
em 27 is marked other than "-"
ther hause. 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code U.S.A. 21207 4914 Challedon Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 ☐ Never Married 2 ☑ Married Black 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Members and injury or control of the state of Rosetta Green James Gassaway ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4914 Challedon Road Baltimore, Maryland 21207 William E. Thornton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 05/19/09 Western Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tury of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** obstructive monar 64 disease or condition resulting in death) CHRONG /Medical Due to (or as a consequence of): Examiner 09 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner transit Due to (or as a consequence of): burial physician the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter for u 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ NO 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 2 🗆 No 1 □Yes 2 100 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 'Hatural М 1 ☐ Yes 2 □ No 2 ☐ Accident Director; 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

executed pe Box ( o ₫. Division of Vital Records, The hornton Hospital or Attending 24 hours after death.

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within 24 hours a To the Funeral D

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Baltimore, Maryland 21215-0036

W State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

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Dalag 31. Date filed (Month, Pay, Year) 32. Registrar's Signature

Vandana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Van dana

900

Leftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

caton Ave,

29d. Date signed (Month, Day, Year)

Baltimore

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 2009 Kathryn Melissa Moore Thomas MAY 18 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 13, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours 1 □ M 2 🕅 F Maryland 1914 216-14-2965 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 715 Maiden Choice Lane HV-420 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: White 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Economist/Nutritionist Spice Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melissa Catherine Gray Daniel Alexander Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4547 Bonnie Branch Rd. Ellicott City, MD 21043 David M. Thomas/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 05/22/09 Odenton, MD 21. Signature of Funeral Gervice Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Heraly 23a. Part1. Enter the sieease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN STROKE DAYS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 🗷 No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown HYPERTENSION, DYSLIPIDEMIA 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? VASCULAR 24a. Was an autopsy performed? 2 No KIDNE 1 ☐ Yes CHRUNIC 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a Date of Injury (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide

/Medical **Examiner** P.O. Records. Vital ð Division

Baltimore,

The law requires that the death certificate be Hospital or Attending Physician:

**Physician** 

Examiner

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Macinal Examinating neithed at

**Physician** 

Examine

Physician/Medical

Completed by

Be

Certification: To

29a. Certifier

/Medical

Director

Funeral

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Completed

within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I

Medical

State Registrar 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900

EYASU MEKUNEN, M.D. BALTIMORE

31. Date filed (Month, Day, Year)

AIVE . BA
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Sittem Market of Degard heart of the alth and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 May 12, Thomas Margaret /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Caring Place 7700 Uakleigh Road 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan. 2, 19 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🛛 F Pennsylvania 88 Jan. 1921 202-44-5583 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene.

deather than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10h. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
ant. If item 2 is marked other than "natural", or items 23a or 28a-f show ant. If item 2 or 2 is marked other than "natural", or other traumatic event, it is it as the configuration of other traumatic event, it is it as the configuration of the property of 1 ☐ Yes 2 ☐ No Director V٨ Prince William Manassas 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20112 10479 Labrador Loop Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Saltimore, Maryland 21215-0036 Specify: 2 3 X Widowed 4 □ Divorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Beresky Anne Sabow ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10479 Labrador Loop; Manassas, VA 20112 Joel J. Thomas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Our Lady of Hope Cemetery May 18, 200 Tarentum, PA 4 □ Donation 5 □ Xother (Specifentombment 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home icho 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Physician disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No certificate 2 🗆 No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSIS Ed Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

Phatak, 31. Date filed (Month, Day, Tear) MAY 2 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

4924 Campbell Blvd. Suite 200 Baltimore, Maryland 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner 8. Date of Birth Month, Day, MARCH 27 (In yrs. last birthday **Funeral** Sex 1M2 M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: if item 2.13a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprimer; ust be retified at once. BALTIMORS 1 ☐ Yes 2 WNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2123 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE \$ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALISTAN ROAD ROSEDALE MARYLAND ULSCH 5316 DONALD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 880 HARFORD

WANS FUNCEAU CHAPPEL OR MITT

23a. Part 1. Enter the disease, or complications that caused the death. Shock, or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the disease or condition

Immediate Cause (Final disease or condition as the property of the disease or condition resulting in death)

Discourse of the disease of the disease or condition as the property of the disease of the disease or condition as the disease or condition as the property of the disease or condition as the property of the disease or condition as the property of the disease of the disease of the disease or condition as the property of the disease or condition as the property of the disease of HARFORD ROAD PARKVIUE, KUANS FUNERAL CHAPEL I OREMATION Approximate Interval Between Onset and Death **Physician** /Medical o (or as a consequence of) 3 weeks Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sele consequence of) The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Parkinsons Osease, Demintia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 4/29/2009 28b. Time of injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ∐ Yes 2√2 No holled out of bed, found on (1) side 2 Accident 0745 within 24 hours after death To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State)
3632 Wolfkor Blvd, Parkyllo, No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (*Specify*) **RG-**CC323 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5/2d/2009 R171944

State Registrar nichealle

8800 Walther Blvd, Packville, MD, 21234

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Harryon CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5, perFH, G892, 6/16709, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** \_P <sup>M</sup> May 20 2009 9:43 /Medical Margaret Jean Van De Langerijt 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Sacar Security Number -404-64-3008 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1□M 2QF Months Days 65 Director 02/10/1944 Canada Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 3a or 28a-f show 1 be restified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1√2 Yes 2 No Director MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1853 Foxdale Court 21114 U.S.A. d other than "natural", or items 23a event, the World Exercises Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Inventory Control Clerk Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jes 1 an.
Int of Health an.
If them 27 is marks.
Intraumatic ev. marked Barry Edwards Jean Ledger 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other trong. <u>Adrian Van De Langerijt</u> 1853 Foxdale Court Crofton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Ardent Cremation Services: 05/21/2009 Hanower, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licenses Lama C. Hardesty M01197 7522 Connelley Drive, Ste.N, Hanover, Md 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as ' IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performet 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital c 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) 2 Midical Honapolis 60 Mil 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** DENISE MARION VILLANI 8:30 P May 19, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) if Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 ☑ F Director 54 Oct. 29, 1954 080**-**46**-**1778 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Bel Air Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1007 Ellicott Drive USA 21015 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo 2 Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrative Assistant</u> U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Pages 1 and 2 should 2 Mack Emerson Lovett <u>Barbara (nmn) Winter</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gabriel Anthony Villani / Son 1007 Ellicott Drive, Bel Air, Maryland 21015 Important: If item 2 any Injury or other once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State fo 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation Hilltop Service Corp. 5-22-09 Towson, Maryland Fune Service (Service Service 22 Name and Address of Facility MCCOMAS Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple **Physician** Mueloma years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) physician a Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1□ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 2 ER/Outpatient 3□ DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Maryland

Division or Vital Records. P.O. Box 68760

State Registrar

31. Date fled (Month, Day, Year)

29b. Signature and title of certifier

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nyo Min(N, U.) CO2 South Abwood Road #200, Bel Air, MD 21014 32. Registrar's Signature Jarka

29c. License number

045390

29d. Date signed (Month, Day, Year)

May 20th 2009

			Please 1	Type or Print in Black II State of Maryland / Dep					
			For State Registrar		ertificate of Death	Reg.	-211114 16587	i	
	Physicia /Medic	al	Decedent's Name (First, Middle, Last     Virginia     As. Facility Name (If not institution, give	В•	White  4b. City, Town, or Location of Death	The court	Day 44 Year 7009 0 445 M  4c. County of Death		
	Examin	er	Season's Hospi		Randallstow	Baltimore			
	Funeral Director		217-22 3201	7. Age (In yrs. last birthda 7. Age (In yrs. last birthda) Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country) NC	n	
	rland ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	ocation		10d. Inside City Limits		
	e Mary 3a-f sh tiffed	Director	MD NA	Balt	imore		1 X Yes 2 No	)	
	a or 21	Dire	10e. Street and Number		10f. Zip Code <b>21215</b>	10g.	Citizen of What Country?		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	3217 Dorithan F  11. Marital Status  1 Never Married 2 Married  X Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	Nest Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black		
21215-0036	hin 72 ho e. an "natur Medical	Completed	15. Decedent's Edi (Specify only highest grad	de completed) (Gir College (1-4or 5+)	edent's Usual Occupation ve kind of work done during most of work DO NOT use retired)	sing 161	b. Kind of Business/Industry		
121	led with		12th grade	na	Domestic 18 Mother's Nam	ne (First, Middle, Mai	Private  (den Surname)		
Maryland	d be fii ental H ked otl c ever	To Be	17. Father's Name (First, Middle, Last)  Willie Brown		Star B				
ary	shoul and M s marl	۴	19a. Informant's Name/Relationship (7		iling Address (Street and Number or Ru				
e, R	l and 2 lealth im 27 i		Linda Anakaraor		Dunnett Ct. Ba	ltimore 200	Md 21236 c. Location - City or Town, State		
nor	ages 1 ant of H t: If Ite y or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		position (Name of rematory or other place) on Forest Vet 5/		Owings Mills, Md		
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygtene. Important: If Item 27 is marked other than any injury or other traumatic event, the Magnice.		21. Signature of Funeral Service Licens	see /	22. Name and Address of Facility larch F/H West 300 Wabash Ave				
		,	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do not e	enter the mode of dying, such as cardiac	or respiratory arrest	t, Approximate Interval Between Onset and Death		
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. A	/Medical Examiner			a. END STAGE CALDI Due to (or as a consequence of): b. Coronary Arte	ALL DISCUS				
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Box 68760,	eath certificate attending phys for use as the	Medi	IF FEMALE:						
Ö	Attending Physician: The law requires that the death certificate be executed or death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year			
rds, P.	quires that n signed b aid be deta	þ	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown	/n	
Division of Vital Records,	ician: The law requires that the de certificate has been signed by the rector, page 2 should be detached	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?	le f	
Vita	ding Physician: The I h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:	Othor	ath (Check only one)	SECASON'S ITUSI	DIL	
of	Phys er this eral dir	٦: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time	e of 28c. Injury at	lome 5 ☐ Residence 28d. Describe how	ce 6 AOther (Specify) injury occurred		
ion	ath. ath. or: Afte	ation	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		y Work? M 1 ☐ Yes 2 ☐ No				
Divis	al or Atte s after de l Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)		
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, di niner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	urred at the time, dat	e and place, and due to the cause(s)		
	Voint	M	29b. Signature and title of certifier	Burtin	29c. License number H 45931	290	d. Date signed (Month, Day, Year)  May 19 2009		
	41		30. Name and address of person who	completed cause of death (Item 23a) (Type 129 35 Sm 32. Registrar's Signature	De, Print)  1. Hy Nonve Ba	Ithmore	MD 21209		
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature					
	Regist	rar	MAY 2 2 2009	plewer B. gar	Co.			_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G892, 6/3/09, WS#20a, perFh, C892, 6/4/09, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Fannie Mae Wooten May 2009 9:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. 1 □ M 2√2 F Months Days Hours 106-28-0433 90 11-14-1918 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Walker Avenue 1430 21239 SA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
3rd grade College (1-4or,5+) Private Homes Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John McKinsey Laura McKinsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Wooten-Son 1430 Walker Avenue Balto, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/29/2009 Greenmount Crem Woodlawn Cemetery Balto, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H lady B W anne 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pheumonia dan Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, hash certificate or Attending Physician: After this

ng physician and as the burial-transit the attending physician ned for use as the buria cate has been signed by the a page 2 should be detached it funeral director, To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A the 1 filled in by

by Physician/Medical Examiner Completed Be Medical Certification: To

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

28a-f show

Director

Funeral

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Be Completed

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ir than "natural", or items 23a or 28a-f sho

Baltimore, Marylan'd 21215-0036

Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene.

Is marked other

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau

**Physician** 

/Medical

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident

3 ☐ Suicide 4 ☐ Homicide

6 ☐ Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

29c. License number 00043489 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6535 N. Charles 12. Se, 550

32. Registrar's Signature

and manner stated.

State Registrar

completely

MAY 2 2 2009

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09-038	83
Benny	Watson

Benny	/ Watson	1.	Fiedse Tyl Si For State	tate of Maryl	and / D	epartme Certifica	ent of	Health Death	and I	Mental	Hyg	iene Rej	g. No.	6	200	9 1658
	Physicia	Re	ngistrar Decedent's Name (First, Midd	ile,Last)							2.	Date of Death Month May 15, 20	Day	Year		Time of Death 1917 hrs
Medi	cal Examin	er B	ennie Melvin V	<i>N</i> atson			14	h City To	vn. or Lo	cation of D	eath	May 15, 20	109 4c.	County of	Death	
(		4	a. Facility Name (if not instituti Sinai Hospital	on, give street and n	iumber)			Baltimo	ore					n/a		
	Funeral Director		. Social Security Number 12–88–1990	6. Sex		n yrs. last birtl	nday) Yrs.	If Under Months		If Under 2 Hours		8. Date of Birt			i Foreian	ace (State or ry)Alabama
		H	Isual Residence of Decedent	122 101											10	d. Inside City Limits
	any		0a. State 10b. County	/		c. City, Town Baltim		on								X Yes 2 No
S	f show	ē	Maryland n/a			Daltin	OLE	10f. Zip C	Code			1	0g. Citi	zen of Wh	at Country	n
472	e Mary or 28a- ied at	Director	0e. Street and Number 322 Denmore A	.ve.				21	215						ed St	
,	eath with the Maryland items 23a or 28a-f show ust be notified at once.	틸	11. Marital Status	12. Was D	ecedent Ev	er in U.S.	13. Wa	s Deceden	t of Hisp	anic Origin Mexican, F	? (Spe	cify Yes or No	)-	14. Race White		n Indian, Black,
	r item	Funeral	1 Never Married 2	1 Yes		No	l							Specify:	Blac	:k
	after cral", o	by F	3 Widowed 4 X E	Divorced If Yes, Give Y		eted) 16a	Deceden	Yes 2	ccupatio	on (Give kir	nd of wo	ork done	16b.		siness/Ind	
	hours "natur	ted.	15. Decedent's Education (5) Elementary/Secondary (0-1)		e (1-4 or 5+		during m	ost of work	ing life.	DO NOT us	se retire	ed)		mo C	onru	
	136 thin 72 than than edical	Completed	10				CE	ement,			N /	First, Middle,	Maider		onry	
	5-00 led win Hygier other	ै	17. Father's Name (First, Midd	le, Last)					1			Mille		Comanic	,	
	21215-0036 Duld be filed within 7 Mental Hygiene. I marked other than ic event, the Medica	Be .	James Watson 19a. Informant's Name/Relation	nship (Type, Print )		19	b. Mailin	g Address	(Street	and Numb	er or R	ural Route Nu	mber, (	City or Tov	vn, State, 2	Zip Code)
	MD 2 nd 2 shoul alth and M m 27 is m	٤	Marion W. Stan	ley/siste	r	1	322	Green	MOOC	d Rd.	E	Saltimo	re,	עויין	2120	own, State
	e, M I and 2 Health item 2		20a. Method of Disposition  1 X Burial 2 Crema	2 Domovi	al from State	20b. Place					.,	Date				Maryland
	nor Pages ent of nt: If					°lDullan	ev Va	allev	Mem	Gard	May	22,200				
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Italiah and Wannell Hygiera. In program: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other 21. Signature of Funeral Serv	ice Licensee			Jol	name and	Address Mi_tc	hell hell	ΙV,Ι	Funeral	L Se	rvice	s of 1	Dulaney Val 193
			GOME Ester the disease	or complications th	at caused t	he death. Do	200 not enter	the mode	ado of dying,	n1a K such as ca	C. ardiac or	r respiratory a	rrest, s	hock, or h	eart	Approximate Interval Between Onset and
	Physician /Medical		failure. List only one cal	use on each line.	rosc1	erotic	card	diova	scu1	ar di	isea	.se				Death
1	caminer	1 1	Immediate Cause (Final dise or condition resulting in death	Due to (or	as a conse	quence of):										
1			Sequentially list conditions,	b	as a conse	guence of):										
		ine	if any, leading to immediate cause. Enter Underlying Car	use c.							_					
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	ox 68760, eath certificate be executed attending physician and for use as the burial - transit	Jed i	IF FEMALE:			ne of pregnan	су		0.0			11-3		23d. Date Month	of delivery	Day Year
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici for the Funeral Libertor. After this certificate has been signed by the attending physicil to the Funeral Libertor.	siclan/Me	23b. Was decedent pregnant past 12 months?	in the 1 L	ive birth	time of death	2	Fetal death Other (Sp		Ectopi	c pregna	ancy	- (	Month		, ay
	ox 6 eath cer eattendi for use	/sicl	1 Yes 2 No 9	Unknown g	Jnknown										-tributo to	the cause of death?
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	ords w requi	ompleted	Ü									pe	utopsy erforme		death?	completion of cause of
	RecC The law	E	1						00 FI	ce of Death	Chaol	1.62	es 2	No	1 🗸 Y	es 2 No
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ime	F Vid Physic er this	ျှ		28a.	Date of Inju	ury 2	Bb. Time			jury at Wor		28d. Descr		v injury oc	curred	
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7	Division Hospital or Attendi 24 hours after death.	Certification: T	2 Accident 3 Suicide 6	Could not be 28e	. Place of Ir	njury - At hom	e, farm, s	treet, facto	ry, office	e building,	etc.	28f. Location	on (Stre vn, Stat	eet and Nu te)	imber or R	ural Route Number, Ci
#	Div	in in	4 Homicide	determined (Sp	ecify)					1-1	1000 0	nd due to the	cause	s) and mai	nner as sta	ated.
	E Hospita	×1 -		ing Physician: To the	ne best of m	ny knowledge amination and	, death oo /or invest	ccurred at t tigation, in	the time, my opini	on, death o	occurred	at the time,	date an	d place, a	nd due to t	the cause(s)
	To the within To the	Medical	29b. Signature and title of o	and ma	nner stated	l				nse numbe			1	29d. Date	signed (M	onth, Day, Year)
4		2	10000	Dolla	, 22			- }	0.0	C.M.E.				May 16	, 2009	
		-	30. Name and address of p	erson who complete	ed cause of	death (Item 2	3a)		_			04004				
	Ø v	/	Margarita Korell N	MD. Assistan	t Medica	l Examine	r 11	1 Penn S	Street,	Baltimo	re, MI	21201				
		Stat	PERIO	2°2 2009	32. Degistr	rar's Signature		lake	,							
		jistra			m	To for	ORIGI								OCME	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar amend 27,29 per DR. g981 5 /Qentitionate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Day )anuas /Medical 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death to to more Medical ater more If Under 1 Year 5. Social Security Number 9. Birthplace Country) **Funeral** Days Months 1 M 2 □ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "textiled at Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DITTES Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after of the filed within 72 hours after of the filed the filed of the filed 27 Is marked other than "natural", or ite 1 Never Married 2 Married 1 □Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 14 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address J Facility 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** me / /Medical Due to (or as a consequence of Examiner 0 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month 5 ☐ Other (specify) Division of Vital Records. P.O. signed by the 2009 Unknown 06 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month; Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0008920

09-03898 Todd Wilson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

odd Wilson		State of Maryland / Departure Cert	rtment of tificate of		Mental H		. No. 200	9   659
Physicia	ın/	Registrar  1. Decedent's Name (First, Middle,Last)				2. Date of Death Month May 16, 20	Day Year	3. Time of Death 0930 hrs
ledical Exami	ner	Todd Dean Wilson  4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or L	ocation of Death	May 16, 20	4c. County of Deat	
		6422 Golden Oak Drive		Linthicum He	eights		Anne Arunde	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24Hrs	7	(MM/DD/YYYY) 9. Bi Forei	gn
Director		214-58-8317 X M 2 F 57	Yrs.	months Days		Jul. 6,	, 1951   <sup>c</sup>	ountry) MD
any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location	on				10d. Inside City Limits
<b>★</b> , 1	5	MD Anne Arundel		Linth	icum			1 Yes 2 X No
Maryla 28a-f	Director	10e. Street and Number		10f. Zip Code	21090	10	g. Citizen of What Cor United St	· ·
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygienc. 7 is marked other than "natural", or items 23a or 28a-f sho naite event, the Medical Examiner must be notified at once.		6422 Golden Oak Drive  11. Marital Status 12. Was Decedent Ever in U.	S 13 Was	Decedent of Hisp		pecify Yes or No-		rican Indian, Black,
eath w items	Funeral	1 Never Married 2 Married Armed Forces?	If Ye	es, specify Cuban,	White, etc.			
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5-0036 led within 72 Hygiene. I other than	-	17. Father's Name (First, Middle, Last)		1		e (First, Middle, M	laiden Surname)	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	Herbert Wilson  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street	Edna and Number or		ber, City or Town, Sta	te, Zip Code)
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re, rand Thealt Healt If item			Place of Disposi crematory or oth <b>EST ATU</b>	ition (Name of center place)	netery,	Date	20c. Location - City of	or Town, State
altimore, rmit. Pages I ar spartment of He pportant: If ite		4 Donation 5 Other Specify:	Cremato	rv	5-	27 <b>-</b> 2009_	Odenton,	MD
Baltimore permit. Pages 1 Department of F Important: If i		21 Signatur of Funeral Service Desgrap	22. N	20 Culph	of Facility Am	brose fu na Pd	neral Home Arbutus, M	nc. Inc. D 21227
Physician	1	29a. Part I. Enter the disease, or complications that caused the death.	. Do not enter th	ne mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atheroscl	erotic Cardi	ovascular Dis	ease			Death
Kammor		or condition resulting in death)  Due to (or as a consequence or	f):					
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lospita Fours I hours uneral		29a. Certifier 1 Certifying Physician: To the best of my knowled	dge death occu	rred at the time. d	ate and place, a	nd due to the caus	se(s) and manner as s	tated.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one 2 Medical Examiner: On the basis of examination a and manner stated.	and/or investiga	tion, in my opinior	, death occurred	d at the time, date	and place, and due to	the cause(s)
F \$ F 8	Me	29b Signature and title of certifier		29c. Licens			29d. Date signed (	Month, Day, Year)
	1	() (Glor (afelly)		0.C.	IVI.⊏.		May 17, 2009	
20+1	1	30 Name and address of person who completed cause of death (Iten Laron Locke MD. Assistant Medical Examiner		Street, Baltir	more, MD 21	1201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signat		back		_		
Regis		40 0 M (3 (1) (1) (1) (1) (1) (1) (1)	13.14	4				

DHMH 17 Rev 1/2001 OCME 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Edwin Charles Waters Jr. May 2009 16 4b. City, Town, or Location of Death 4c. County of Death N/A B<u>altimore</u> If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Months

For State Registrar 1. Decedent's Name (First, Middle, Last) Physician 11:00 P.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner Joseph Richey Hospice 8. Date of Birth (Month, Day, Year) 06/07/1950 9. Birthplace (State or Foreign Country) Maryland Social Security Number **Funeral** 220 54 4130 58 Director Usual Residence of Decedent 72 hours atter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once. 1X Yes 2 □ No N/A Baltimore Director Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21223 U.S.A. 1106 Sargent Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within Elementary/Secondary (0-12) 7th College (1-4or 5+) Allied Roofing Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin Charles Waters Sr. Golda Short 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3164 Ryerson Circle Baltimore, Maryland 21227 Crystal Waters / Daughter Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/20/2009 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused it death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respondent Factine **Physician** disease or condition resulting in death) /Medical Due to or as a con equence of): **Examiner** Squanan (ell (creinin à obstruction (Ay II) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an -stank autopsy performed After this certificate Alcohol 2 11Ko Heavy 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) INPAT/6 NT Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie (MD) 05/18/2009 D041476 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of Vital Division 21204 W. Wilson 6565 N CHARLES ST STE 416 BALTIMORE RAYMOND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

5/10/10

		For State Registrar	State of Maryla		epartment o Certificate o		vientai Hy	Reg. No. 2	009	16593
Physicia	an	Decedent's Name (First, Middle, Leonard	Francis	7.	ajdel	Jr.	2. Date of Do Month	Day	Year 2009	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, g				n, or Location of Death			unty of Death	J. 0.
		Franklin Squa	re Hospita		ROSE		9 Date of Bi		1+inn	lace (State or Foreign
Funeral Director		5. Social Security Number 220 36 3692  Usual Residence of Decedent	7. Age (In y 1 1 M 2 □ F 6		Months Da		8. Date of Bi (Month, D 01/22/	1942	Mary	ntry)
yland now		10a. State 10b. County	10c.	City, Town	or Location	- <u>-</u>			10	0d. Inside City Limits
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th with th	Funeral Director	10e. Street and Number 2109 Redthorn Roa	ad			21220			of What Coun	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examinar must bu notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 196		13. Was Decedent If Yes, specify ( 1 □Yes 2 🔀	of Hispanic Origin? (S Cuban, Mexican, Puert No <i>Specity:</i>	specify Yes or N to Rican, etc.)	Sp	Race - Americ Black, White, e ecify: whi	etc. Lte
21215-0036 d within 72 hours af giene. r than "natural", or	Completed	15. Decedent's (Specify only highest)		16a.	Decedent's Usual Oc (Give kind of work do life. DO NOT use re	one during most of wor	rking	16b. Kind	of Business/Inc	dustry
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and and other seed other cevent,	Be	17. Father's Name (First, Middle, La	•			18. Mother's Nar	<sub>ne (First, Middl</sub> ieve	e, Maiden Sui <b>Gutc</b> l		
aryla aryla and Mer	မ	Leonard Francis 2		19b.	Mailing Address (St	reet and Number or Ri				Code)
nd 2 s alth ar 27 is er trau		Joyce E. Zajdel	(wife)			rn Road Mi		ver Ma:	ryland	21220
or other		20a. Method of Disposition 1   Burial 2 □ Cremation 3			Disposition (Name of y, crematory or other		Date		ion - City or To	
Baltim Baltim permit. Pag Department Important: I		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Fureral Server Lice	cify) H	olly		Garden's 5/				
Ba perm Depa limpo any i		21. Signature of Furreral Service Life				d Eastern				
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Physician	ř	Immedi e Cause (Final disease disease	_a. Pneumo	mia						Onset and Death
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Box 68 eath certifica	/Med	IF FEMALE:	23c. If yes, outcome of pre	egnancy		-	F/1	230	d. Date of deliv	/erv
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P.C		9  Unknown  Part II. Other significant condition	s contributing to death but not	resulting in	the underlying caus	e given in Part I.	23e. Die	d tobacco use	contribute to t	the cause of death?
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Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification: To	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my xaminer: On the basis of exa and manner stated.	knowledge mination ar	e, death occurred at nd/or investigation, in	the time, date and plan my opinion, death occ	ce, and due to t curred at the tin	he cause(s) a ne, date and p	nd manner as lace, and due	stated. to the cause(s)
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10+1		30. Name and address of person w	ho completed cause of death	(Item 23a)	(Type, Print)	A	) D	11	O MAN	01127
1	ate	31. Date filed (Month, Day, Year)	32. Registrates 5	Signature		Square D	rive, b	21+1110	E, MID	थावजा
Regist		MAY 22	2009 Senera	1	pares					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** May 8, 2009 Penny Renee Bowen 6:40 Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 216 Brent Road Waldorf Charles 8. Date of Birth (Month, Day, Year) 12/27/1964 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours 214-76-3959 44 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Even inst must be notified at 1 ☐ Yes 2 TVNo Director MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a 216 Brent Road 20602 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumath. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: Completed by Specify. white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lvle German Bowen, Jr. Katherine Eileen Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine E. Quade, mother 2510 Ross Road, St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Church Cemetery 05/14/2009 Port Republic, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complication shock, or heart fail, i.e. List only one s that caused the death. Do the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betw Immediate Cause (Findisease or condition resulting in death) **Physician** /Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence P.O. Box 68760 Physician/Medical as IF FEMALE: yes, outcome of pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item

Year)

23a) (Type, F

32. Registras Signature

			For State Registrar	State of Marylan		artment of I rtificate of			giene Reg. No. 200	9 16595
	Dharist		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month		3. Time of Death
	Physicia /Medic		James Garnel	l Brown				May	1,200	
-	Examin		4a. Facility Name (If not institution, give				r Location of Dea		4c. County of [	
7			9930 Rosaryvil		last hirthday	Upper If Under 1 Year	Marlbo			George
	Funeral Director		5. Social Security Number 6. Se	XM 2DF	Yrs.	Months Days	Hours Min		y, Year) 11920 M	Birthplace (State or Foreign Country) aryland
			579-24-7403 Usual Residence of Decedent	88			1	12/30/	1020 11	aryrana
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation	-			10d. Inside City Limits
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Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or ot		21. Signature of Superal Service Licen		22	2. Name and Addr	ess of Facility			
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<u>P</u> .	that the de ned by the detached	Phy	Part II. Other significant conditions of	antributing to death but not res	ulting in the u	nderlying cause di	ven in Part I	23e. Did t	obacco use contribu	ute to the cause of death?
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Rec	has ge 2 g	mp						- autor	psy prio	or to completion of cause of ath?
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Division	or Attending Physician: The law requires that the death certifulate death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, sti	reet, factory, office		28f, Location ( City or To		or Rural Route Number,
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	To the Hospital within 24 hours a To the Funeral I completely filled	Mec	29b. Signature and title of certifier	and marmer stated.		29c. Licer	se number		29d. Date signed (	Month, Day, Year)
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	<i>b</i> .		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	D. dA				
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	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	have 1	*,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 5, 2009 3:37 P M William C. Barry , Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Nov 13, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday Months Days 1 √ M 2 □ F 1940 Altoona, 202 30 1077 68 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 XXVo Marvland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 111 02 welch Street United States 20735 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Affiled Folder: IXYes 2□No IfYes, Give Year or Dates: Vietnam 1 Never Married 2 Marr 3 Widowed 4 Divorced 2 Married Specify 1 □ Yes 2√TVNo Specify: White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOD Air Force Retired 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Dean Barry Stephanie Potopa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lisa Greene (Daughter) 14 Upman Court, Catonsville, MD 21228 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State West River, Maryland OUR LADY OF SORROWS CEMÉTERÝ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Signature Funeral Sep Alexandria Ferry Road, Clinton, MD M00257 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 [ 25. Was case referred medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1/ Natural

Physician /Medical Examiner requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Experience and be notified at

death with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Examiner physician and s the burial-trans attending properties as as signed by the a page 2 certificate I director,

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

þ Completed Be Certification: To

Physician/Medical

il or Attending Physician: after death. After this ( funeral din Director: d in by the f filled in within 24 hours a

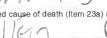
State Registrar

To the Hospital

Medical

31. Date filed (Month. Day. Year)

6 Could not be determined



Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type\_Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 8, Day 2009 Year **Physician** Margueritte T. 10:10 AM Bryan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ManorCare Silver Spring Montgomery If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Oct 29, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days 1 □ M 2**X** F 92 1916 Kentucky Director 404-28-6809 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f shov Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2723 Jennings Road 20895 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nortant if item 27 is marked other than "nortant in the 27 is marked other than "nortant in t Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No ģ If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Elementary School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Tignor Ella Logan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daniel L. Bryan/son 8329 Sweet Cherry Lane Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State W. Arundel Crematory 05/11/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signate of Funeral Service Licenses Going "Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Disease months /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation years Sequentially list conditions Examiner Euro for as a consectioned off if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Coronary Artery Disease months Due to (or as a consequence of). burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Failure to Thrive 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ∐Yes 2 □ No 2 Accident d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled ir 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Mydical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D19609 May 8, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman Tuli, M.D. 10810 Darnestown Road #202 Gaithersburg, MD 20878

State Registrar

Box 68760,

P.0.

Division of Vital Records,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

32. Registrar s Signature

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ye ar **Physician** 2009 1815 Mary Margaret Smack Bhatti May 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🖫 F 220-26-1810 MD Director Aug 18,1931 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Modical Examinar must be notified at 1 ☐Yes 2 ☐ No **Funeral Director** MD Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 227 Branch Street 21811 <u>USA</u> 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ∐Yes 2 ∐XNo Black Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Families 11th Homecare Provider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John D. Smack, Sr. မ Rosie Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra once. John D. Smack, Jr./brother 223 Branch St., Berlin, MD 21811 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Burial 2 Cremation 3 Removal from State Paul's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5/08/2009 Berlin, MD <sup>22</sup> Name and Address of Facility
Lewis N. Watson Funeral Home, PA 21. Signature of Funeral Service Licens Masson 1618 West Road, Salisbury, MD 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Masse **Physician** ung /Medical Due to (or as a consul ence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cuit to for as a consequence of Physician/Medical Examiner that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ②No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes signed by the a o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an has autopsy certificate 1 Yes 2 0 Vital 1 □Yes Hospital or Attending Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ Division of After this funeral of Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Szymala, MD, 1733 Healthway Drive, Berlin, MD 21811 Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 6599 Reg. No. 4 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Angelina L. Caputo May 6, 2009 2:22 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery General Hospital Olney Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min 1 □ M 2 🕱 F Months Days Hours Director 92 Washington, DC 577-18-2688 Sept. 1, 1916 Usual Residence of Decedent the Maryland 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 ▼No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9508 Warren Street 20910 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Race - American Indian. Black, White, etc. be filed within 72 hours after and Hygiene. ed other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 🙀 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government \$ecretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H Antonio Chite Antoinette Lombardo ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important; If Item 27 Is any injury or other trausonce. Rose Marie Howard/Daughter 16901 Batchellors Forest Road, Olney, MD 20832 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 12, 2009 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Sign fure of F neral Service Lice e 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Truchard I Anles 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) NEWN /Medical Due to or as a consequence of) Examiner Sequentially list conditions, from Louis Cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a construence of): The law requires that the death certificate be executed ending physician and use as the burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 mor Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate Hospital or Attending Physician: Tr 44 hours after death. Funeral Director: After this certificate tely filled in by the funeral director, pag 2 □No 1 □ Yes 2 ☑₩0 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ☐Ho 1 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner - Tath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Whatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cade of death (Item 23a) (Type, Print) Heather lovenzo 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:00 a<sub>M</sub> Month **Physician** 5/ 2009 10/ Antoinette Casalino /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Asbury-Solomons Island Health Center Calvert Solomons 8. Date of Birth 5/11/1917 If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 Ϊ XF Months 91 New York 067-09-3372 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at 1 ☐ Yes 2 No Director MD Calvert Huntingtown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20639 USA 450 Carla Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify White 2 Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Manufacturing If item 27 is marked other or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental Louis Regina Unknown ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 450 Carla Drive Huntingtown, MD 20639 Leonard Casalino (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May Date Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Lee Crematory Clinton, Maryland 4 Donation 5 DOther (Specify) 2009 21. Signatur Fun Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. MO1464 John F. Holmes 8125 Southern Maryland Blvd. Owings, MD 20736 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** HFAR. n 0~7745 ONGETIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IJCHEMIC CARDIOMYOPATITE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit DIJEASE CORONARY ARTERT Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear 1 ☐ Yes 2 ☑ No 5 Other (specify) detached a I I Inknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 **Z** No 2 **N**O 1 Tyes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 1 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2. the

IRW

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Dr./John H. Weigel, M.D. 110 Hospital Drive Prince Frederick, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

29c. License number

D26358

29d. Date signed (Month, Day, Year)

20678

2009

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 08:40 AM May Harry Arthur Christensen, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 1880 Old Philadelphia Road **Elkton** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days Hours 1 XM 2 ☐ F 19, 1940 Maryland Director 68 218-40-1429 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2XXXVo Directo Maryland Ceci1 E1kton 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 21921 1880 Old Philadelphia Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 No Army If Yes, Give Year or Dates 1959-65 1 ☐ Never Married 2 X Married 1 ☐ Yes XXNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Salvage 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma L. Brown Harry A. Christensen, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1880 Old Philadelphia Road, Elkton, Maryland 21921 Linda Christensen / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May Pate 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Newark, Delaware 6 ☐ Other (Specify) Mayerdale Crematory 4 ☐ Donation, un era Service Lio nse 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) unknown **Physician** /Medical Due - for s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed Box 68760, P.O. Division or Vital Records, or Attending Physician:

sician and burial-trans attending physician for use as the buria ed by the a signed by the s certificate has b irector, page 2 sl director, ral Director: led in by the To the Hospital

r 28a-f show notified at

ortant: If Item 27 Is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be

and Mental Hygie

permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trau

ould be f

Maryland 21215-0036

Baltimore,

the

within 24 hour To the Funer сотрете fill	Medical

3+1VA State Registrar

va

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and little of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) ~ MO

6 ☐ Could not be

32. Registrar's Signature Back

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day Year)

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			For State Registrar	State of Mar	,	Certificate o		ariu ivie		Reg. No.	0000	166	503
	DI		1. Decedent's Name (First, Middle, Las						. Date of De	ath	- 11 11 11	3. Time of I	
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	Examin		8899 Arden Station Road Westover								Somers	et	r Foreign
	uneral irector		5. Social Security Number 219–36–5179 6. So 1 1 Usual Residence of Decedent	ax M 2□ F 7. Age (. 69		rs. Months Day		Min.	(Month, Da	'1940		place (State of intry) ryland	- Greigir
yland	wor		10a. State 10b. County	1	0c. City, Town	or Location						10d. Inside Cit	•
e Mar	Ba-f sl	Director	Maryland Somerse	et	West							1 □ Yes	2 <b>X</b> No
d 6 16 15 15 15 15 15 15 15 15 15 15 15 15 15	n result and when any specie and any series of thems 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Medical Examination must be rediffed at	ral Dire	10e. Street and Number 8899 Arden Stati	on Road		10f. Zip Cod 2187	L			Ţ	zen of What Co		
er dea	items norm	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 KN Yes 2 □ No	er in U.S.	<ol> <li>Was Decedent of If Yes, specify C</li> </ol>	of Hispanic Ori ouban, Mexican	gin? (Speci , Puerto Ri	ify Yes or No can, etc.)	0-	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>		
urs aft	al", or Exami	by	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	Force	1 □ Yes 2 🛣	lo Specify:				Specify: whi	.te	
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and 2 s	27 Is er trau		Shirley B. Creasy			8899 Ardei	n Stati	on Ro	l., We	stove	er, MD 2	21871	
Pages 1 and 2	nt: If Iten ry or oth		20a. Method of Disposition  1 □ Burial 2 🖾 Cremation 3 □  4 □ Donation 5 □ Other (Specify		20b. Place of I cemetery Salisk	Disposition (Name of crematory or other poury Crema	tory	5/5/0		_	isbury,		
permit.	Important: If Item 27 Is any injury or other tra		21. Signature of Funeral Service Licen	see	cree	Holloway 501 Snow	funera Hill	al Ho	me Pro Salish	ofess ourv,	sional A MD 218	ssociat 04	ion
			23a. Part 1. Enter the disease, or comp	plications that caused th	e death. Do no			-				Approximate Interval Bet	•
√ Phy	sician		shock, or heart failure. List only immediate Cause (Final disease or condition	Metas	tie po	only with	even tie	ated C	encin	once	2	Onset and E	
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be death	the atter ched for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Pregnant at ti 9 ☐ Unknown		3 ☐ Ectopic pregn 5 ☐ Other (specify					Month		<b>Ye</b> ar
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equire	en sig ould be		-						1 🗆	Yes 2	□ No 3□ P	robably 4 🔀 l	Jnknown
The law requires that the death certificate be	ite has been signed by the age 2 should be detached	Completed									prior to death?	topsy findings completion of c	available ause of
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or Atte	Director	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.		m, street, factory, offi	ce	28	Bf. Location City or To	(Street ar	nd Number or R	ural Route Num	ber,
To the Hospital or Attending Physician:	To the Funeral Direct completely filled in by	edical Co	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of niner: On the basis of e and manner state	xamination and	, death occurred at the	e time, date ai ny opinion, dea	nd place, a ath occurre	nd due to the d at the time	e cause(s	s) and manner a d place, and due	s stated. e to the cause(s	5)
To the	To the	Mec	29b. Signature and title of certifier	5)		29c. Lic	ense number	-8	2	29d. Da	ite signed (Mont	h, Day, Year)	-
11	YXX		30. Name and address of person who	completed cause of dea	th (Item 23a) (	Type Print) Sal	isbury,	MD 2	21801		1		
•	A		Dr. OTHER TAYLOR	г, тоо п.	~~_ L O 1 1	,							

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 8 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 🗓 🗎 9 1 - For State Registrar Certificate of Death 2. Date of Death Date Month 7, 3. Time of Death 1, Decedent's Name (First, Middle, Last) **Physician** 7:35 PM 2009 May Alexandria Pederson Du Bois /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 4712 Cumberland Avenue Chevy Chase Birthplace (State or Foreign Country)
 New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2X F 98 10. 218-38-8388 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Exprintment and the restlined at 1 ☐ Yes 2 ▼No Director MD Montgomery Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20815 USA 4712 Cumberland Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White Specify: 2 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Education d 2 should be filed w th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johanna Pederson Nils Pederson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Roxane Du Bois/daughter permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. 4712 Cumberland Avenue Chevy Chase, MD 20815 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State W. Arundel Crematory 05/11/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service L MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Vascular Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑No 3 Ectopic pregnancy Day Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 4No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be 1 Tes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? After 1 X Natural 5 Pending investigation after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 24 hours a 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier May 8, 2009 MO31148 MAD ress of person who completed cause of death (Item 23a) (Type, Print)
McBreen, M.D. 3301 New Mexico Ave. NW Suite 205 Washington, DC 20016 30. Name and Brian f. McBreen, M.D. 31. Date filed (Month, Day, Year) MAY 11 2009 32. Registrar's Signature State parker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend 10a-f, 17,18 per hosp Cerificate 5/23/200 kh Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SKEETER 20133 P 2009 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner GROVE ADVONTIST HOSPITAL ROCKVILLE, MARYLAND MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Hours Min. (Month, Day, O 4 O 3) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Funeral 1 M 2□F NONE MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits : if item 27 is marked other then "neturel", or Items 23a or 28a-f show or other treumatic event. The Modical Exercities plast be notified at TX Dallas Dallas 1 Yes 2 No Director 10e. Street and Number 2300 Canton St. #1202 10f. Zip Code 75201 10g. Citizen of What Country? USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: If item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) INFANT NFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Elbert Ellis Danya Khalilah Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Importent: If item 27 Is any injury or other treu QDCS. ELLISI FATHER 2300 LANTON STREET # 1202, DALLAS, TX JAMES 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State HALL RIVER, NC STERI 05/04/2009 CYCLE ¹ 4 ☐ Donation 5 Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility 20850 GAH, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MB 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PREMATURITY Immediate Cause (Final disease or condition resulting in death) EXTREME **Physician** /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2× No 3 ☐ Probably 4 ☐ Unknown Be Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 : autopsy performed 1 Yes SNO No 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \)

**Examiner** requires that the death certificate be execu attending physician for use as the burial Division of Vital Records, P.O. Box 68760 certificate has

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifications and the funerel Director. within 24 hours after dea To the Funerel Director completely filled in by th

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and the of ertifie

29d. Date signed (Month, Day, Year)

61737

es of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 9901 MEDICAL CENTER DRIVE ROCKVILLE, MARYLAND 20850 JATTY SENESIE MD,

2. Registrar's Signature

State Registrar **Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show

Directo

Funeral

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Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical once.

Baltimore, Maryland 21215-0036

attending phase for use as t signed by i this certificate

Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After completely filled in by the funer.

Division or Vital Records, P.O. Box 68760,

Medical drw) State

Physician/Medical þ Completed Be မ

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

WD

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29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Hospital 31. Date filed (Month, Day, Year)

Prince Frederick 32. Registrade Signature

mD 20678

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** Irene E. Goswellin 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MEDICAL HIGMIC ROGIONAL 59/15647 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F 226-40-2912 86 Director Dec. 31, 1922 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ira Madical Examiner must be multihed at once. 1 X Yes 2 □ No Director Pittsville MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 35113 Early Glow Court 21850 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2**½%**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: ģ white 3XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shirt Folder Garment Company 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lydia Hale Rufus Miller ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pittsville, MD 35113 Early Glow Court Janice M. Merrill (Daughter) 20b. Place of Disposition (Name of cemetary crematory or other place)
Snow Hill
Christian Church Cem.May 11, 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Snow Hill, Maryland 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee 13 East Grove Street Delmar, DE 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 41 /Medical Due to (or as a consequence of): Examiner 15 CHRMIL INFEETINU Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy for Yea Day 5 ☐ Other (specify) been signed by the sales should be detached for ☐Yes 2 No 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, page 1 ☐Yes 2 ☐ No Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1711 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 27.8 Chodnic Jennis. 32 Registrar's Signatu 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1322 PM FERNANDO February 2009 arcia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Sount Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min. 1**X** M 2 ☐ F laryland Director February 6 2009 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Extra the Franch once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Baltimore 1X Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Monica USA 21207 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces? ☐Yes 2 No Never Married 2☐ Married altimore, Maryland 21215-0036 1X Yes 2 No Specify: Handuras If Yes, Give Year or Dates: Specify: Hispanic þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) newborn none newborn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leticia Garcia UNKNOWN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 120 7 19a. Informant's Name/Relationship (Type. Print) Monica Place Baltimore Maryland Jenny Leticia Garcia, mother 6311 May 01, 2009 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland New Cathedral Cemetary 22. Name and Address of Facility SAIWT AGNES HOSPITAL 21. Signature of Funeral Service Licenses m per De advantores BALTIMORE, MARYLAND 21229 900 CATON AVENUE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician prematoriti severe disease or condition resulting in death) /Medical Due to (or as a consequence o) **Examiner** Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 No 1 ☐Yes after death.

Director: After this certific
I in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0037452 messer M.D may 16,2009

State Registrar

DHMH 17 Rev 1/2001

Baltimore,

Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caton

900

31. Date filed (Month, Day, -Year)

Avenue

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - Registrar AMEND#10-perFH5/19/09, BW, MCO

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** MONTE HERMAN 7:15 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number Greater 4c. County of Death 4b. City, Town, or Location of Death Examiner HEBREW of HOHE MONT GOTIERY ROCKVILLE Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Months | Days | Hours | Min. | 4 Ug. 7, 193 Sex 1/1 M 2 F 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Washington, DC Months 74 1934 Director 577-46-1120 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, "ne Medical Evantina must be notified at Montgomery Potomac 1 ☐ Yes 2 ☐ No Director 10e. Street and Collegstream 12005 Clodstream Drive 10f. Zip Code 10g. Citizen of What Country? death with 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes X□No 3altimore, Maryland 21215-0036 White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, The Mendones. Elementary/Secondary (0-12) College (1-4or 5+) Physician Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman Louis Bassin raurence <sup>Nam</sup>ferman *(Tyn*n*Ein*hew <del>Lawrence Herman / ne</del>phew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200<u>5 Coldstream Dr., Potomac , Md.</u> 20b. Place of Disposition (Name of Ohev Shollow National Cemetery Comments of Ohev Place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State May 8, 2009 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Jun / Service License 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., N.W., Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COMPLICATIONS Physician OF DEMENTIA year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ ACCIDENT 2 📝 No WITH 1 🗌 Yes 3 Probably 4 Unknown Completed BEN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □Yes 2 ₺No Division of Vital e Hospital or Attending Physician: 24 hours after death. Enneral Director; After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊡ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၀ 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tiff of cer 0-25914 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

6121 MONTRUSE RUAD

BRIMMER, MD

32 Registrar's Signature

ALLEN ISRII
31. Date filed (Month, Day, Year)

MAY 08

ROCKVILLE, MARYLAND. 20852

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hyoiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

	Registrar				Ce	ertificate of	Death	1		Reg. No. 2	009	166
n	1. Decedent's Name	e (First, Middle,	Last)						<ol><li>Date of De Month</li></ol>	Day	Year	3. Time of D
al	Jea 4a. Facility Name (/		zabeth H		<u> </u>	4b. City, Town, o	ar I apotion	of Dooth	May	8	2009 unty of Death	06:25
er	Glen Mea				i + 17	Glen A		or Death			ltimor	
	5. Social Security N		S. Sex	7. Age (In yrs.		) If Under 1 Year	If Unde	r 24 Hrs.	8. Date of Bir (Month, Da	rth		hplace (State or i
	357-12-2		1 □ M 2 <b>XXX</b> F	88	Yrs.	Months Days	Hours		May 21			inois
	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or L	ocation						10d. Inside City
ţo	Man-1 1	Dalad.			01 4							1 □Yes 2
Director	Maryland 10e. Street and Nur	<u>Balti</u> mber	more		Glen A	10f. Zip Code				10g. Citizen	of What Cou	untry?
	11630 G1	en Arm	Road Uni	t 42		21057				Unit	ed Sta	ates
Funeral	11. Marital Status		Armed F	edent Ever in U	.S. 13	. Was Decedent of If Yes, specify Cub	Hispanic O pan, Mexica	rigin? (Spe an, Puerto f	ecify Yes or No Rican, etc.)	o- 14.	Race - Amer Black, White	
by F	1 ☐ Never Marri		If Yes, G	ive		1 □Yes 2 ▼No						Vhite
		15. Decedent's	Year or I	Dates:		edent's Usual Occu				16b. Kind o	of Business/I	Industry
Completed	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  [Selementary/Secondary (0-12)   College (1-4or 5+)											
Son	12	12 Homemaker Own Home										
Be	17. Father's Name	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)								name)		
은		Ralph Fleischer-Hannum  Libble Hadfield  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S								0: -	Tin On Ital	
	19a. Informant's Na Susan C.			ter		ling Address <i>(Stree</i> [armouth ]						Zip Code) 21901
	20a. Method of Dis		, naugn			osition (Name of ematory or other pla			ate		on - City or 1	
	1 ☐ Burial 2	Cremation 3	Removal from	State			i	May00	jo,		-	
	4 Donation 15 Other (Specify) Mayerdale Crematory 12009 Newark, Del 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility Crouch Funeral Home									Lawale		
	1///	127 South Main Street, North East, Maryland21901										
	23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
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l Examiner	disease or condition resulting in death)	nditions, historial erlying injury	c	(or as a conseq	uence of):	Syndr	me, such a	s cardiac 0	in tospinatory a			Interval Betwe
<u></u>	disease or condition resulting in death)	nditions, history rrying injury sast t pregnant ponths?	c	(or as a consequence of pregnibirth 2 □ Feta grant at time of	uence of):  uence of):  uence of):  ancy al death 3	□ Ectopic pregnar	me	Scardiac U	in tospiratory a		. Date of deli Month	Interval Betwe
by Physician/Medical	disease or condition resulting in death)  Sequentially list condition of the cause. Enter Under Cause (Disease or that initiated events resulting in death) I  IF FEMALE: 23b. Was decedent in the past 12 1	nditions, ording ording injury Last t preclant positis?	c. Due to d	(or as a consequence of pregnation of pregna	uence of):  uence of):  uence of):  ancy al death 3 death 5	□ Ectopic pregnar	hne		23e. Did	23d	Month	Interval Betwe
e Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list contains the cause. Enter Under Cause (Disease or that initiated events resulting in death) I  IF FEMALE: 23b. Was decedent in the past 12 1   Yes   2   9   Unknown  Part II. Other signif	nditions, additions, and the control of the control	c. Due to d	(or as a consequence of pregnation at time of one of pregnant at time of one one of the	uence of):  uence of):  uence of):  ancy al death 3 death 5	□ Ectopic pregnar	iven in Part	I.	23e. Did 1 □ 24a. Was auto perf 1 □ Yes	tobacco use Yes 2 1	Month  contribute to	ivery Day The cause of decorposed findings avcompletion of cause
To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list contains the cause. Enter Under Cause (Disease or that initiated events resulting in death) I  IF FEMALE: 23b. Was decedent in the past 12 1   Yes   2   9   Unknown  Part II. Other signification of the cause of the cau	nditions, Inditions, I	C	(or as a consequence of pregnation at time of nown	uence of):  uence of):  uence of):  ancy al death 3 death 5	□ Ectopic pregnar □ Other (specify) underlying cause gi	26. Placther: 4 1	I. Se of Death Jursing Hor	23e. Did 1 □ 24a. Was auto perful □ Yes	23d tobacco use Yes 2 1 2 psy prmed 2 2 1 No one) idence 6	Month  contribute to io 3 Pr.  4b. Were au prior to o death? 1 Yes	ivery Day The cause of decorposably  attopsy findings avecompletion of cause of caus
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Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list contains the cause. Enter Under Cause (Disease or that initiated events resulting in death) I  IF FEMALE: 23b. Was decedent in the past 12 1	nditions, and the state of the	C. Due to  d. 23c. If yes, or 1	(or as a consequence of pregnation at time of anown of pregnation at time of anown of the pregnation o	uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uuence of):  uence	Ectopic pregnan Other (specify) underlying cause given to a DOA of 28c. Initiation M 15c. treet, factory, office ath occurred at the investigation, in my 29c. Licer	26. Place ther: 4 2 vopinion, de	I.  Lee of Death Jursing Hor  No  2  and place, eath occurr	23e. Did  1 □  24a. Was auto perfolicy performance performan	tobacco use Yes 2 1 N an psy ormed? 2 1 No one) idence 6 Now injury or (Street and N wn, State) e cause(s) an , date and pla	Month  contribute to io 3 Pr.  4b. Were au prior to o death? 1 Yes  Other (Spectrumber or Rule)  d manner as ace, and due	ivery Day Ye to the cause of decorbably  Tobably  Tobably

Amended Item 25 per Phy. 05/13/2009 Carroll Co., wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 8:12 P 2009 Joseph Daniel Gurd 4 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll County 845 South Main Street Hampstead Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Year Months Days Hours 1 X M 2 □ F 1 026-12-3329 84 Dec. 1924 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Director Maryland Carroll County Hampstead 10a. Citizen of What Country's 10f. Zip Code 10e Street and Number United States 845 South Main Street 21074 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1941 – If Yes, Give Year or Dates: 1945 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) supervisor paint company 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Daniel Hurd Irene Clifford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joann Garrity - daughter 3202 Shiloh Road Manupstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 8, Glen Burnie, Maryland Glen Haven Mem. Park 2009 22. Name and Address of Facility Eline Funeral Come 21. Signature of Funeral Service Licensee M00741 934 South Main Street Hampstead, Maryland 21074 X Lemmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 YEARS COPD resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ctopic pregnancy Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? WITH CHF 24a. Was an PREVIOUS MI autopsy performe (es 2) 1 ☐Yes 2 ☐ No INDVSTRIAL CHEMICAL 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \sum \) Nursing Home 5 Residence 6 ☐ Other (Specify) 1X Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 2 ☐ Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

attending physician and for use as the burial-transi the attending be detached signed by this certificate has uneral

**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expanding 1: stat be notified at

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

frey CHIVAIL State

e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Certification: To completely filled in by the Medical To the h within 2

29c. License number 29b. Signature and title of certifier

0000 D 29301

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FINKS BURG, MD 21048 GAMBER RD 3000 TVLLY

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

32. Registrar's Signature barks

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 PM May 2:00 Peggy Lou Humphrey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Prince Georges County Hospital Cheverly If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖸 F 2/16/1940 551504840 69 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, It. Marical Experimental Once. by Funeral 1205 Legos Choice Ct. 21157 <u>United States</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify.White 3√Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bartender Resturant/Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Lelia Eldora Fitch <u>Homer Tony Meeks</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry O Humphrey (son) 1205 Legos Choice Ct. Westminster, MD 21157 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) S. Carroll Crematory 5/6/2009 Winfield, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such a caused the death. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or conditio resulting in death) Septic Shock /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Ventilator Dependant Respiratory Failure Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical COPD IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

1156 2

State Registrar

Cumberbatch phnell 31. Date filed (Month, Day, Year)

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Knews

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Leona Joyce House 2009 Mav /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Arrowhead Ct. Baltimore Pikesville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 5 **Funeral** Year Hours Months Davs 1 □ M 2 🗓 F 212-30-5346 1933 76 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ms 23a or 28a-f shor Pikesville Baltimore Maryland 1 ☐ Yes 🎗 🐼 No Director the 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with United States 21208 2 Arrowhead Ct. Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any Injury or other traumatic event, the Medical Examine man once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 2**XX**No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ X1100 þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Transportation 12th Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Essie Mae Lewis Howard L. Tatum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
723 Delaware Ave. Glen Burnie, MD 21060 19a. Informant's Name/Relationship (Type. Print) Mr. Keith House 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Timonium, Maryland Dulaney Valley Mem. 4□Dongajon 5型Other (Specify) Entombment 22. Name and Address of Facility 21. Signature f Funeral Service Licensee Burrier-Oueen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD 23a Pa / L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final use se or condition relating in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the huria IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 24 hours after death.
Funeral Director: After this certificate I etely filled in by the funeral director, page 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home State Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

If the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

If the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 2 ☐ Medical B 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number

State Registrar of person

31. Date filed (Month, Day, Year

why completed cause of death (Item 23a) (Type, Print

Registrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Mary Catherine Hobbs 6230M 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Scalis by Ry 5. Social Security Number Rehab INURS, C Wicomico md 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Days 91 218-16-7619 01/31/1918 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Salisbury Maryland Wicomico Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Items 23a 21804 USA 200 Civic Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married ☐Yes 2 XNo 6 1 □Yes 2 XNo Specify þ Specify: white 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) secretary insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Pages 1 and 2 should be Louise Heath Elisha Burns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 920 James Court, Salisbury, MD 21804 Department of Health a Important: If item 27 is any Injury or other trainonce. Roberta Mason/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 5/6/09 4 □ Donation 5 □ Other (Specify) Salisbury Crematory Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Light Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or com shock, or heart failure. List only complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending To the Hospital or Attendi within 24 hours after dea h. To the Funeral Director A completely filler in by the fu 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 William 31. Date filed (Month, Day, Year) State MAY 0 8 Registrar

09-03533 <sup>**</sup> Humbird Lynn Jo	hņs	Please Type or Print in Black Indelible Ink. Ensur on State of Maryland / Department of Health an						
Physicia Medical Examir	n/	Registrar  1. Decedent's Name (First, Middle, Last) Humbird Lynn Johnson		Reg. 2. Date of Death Month D May 2, 2009	NO.	3. Time of Death		
(		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or 1000 Beglan Park Apt. 104 Salisbury	r Location of Death	May 2, 2009	4c. County of Dea			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes Months Day			(MM/DD/YYYY) 9. E	Sirthplace (State or Foreign Country) Maryland		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "untural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Quba	n, Mexican, Puerto	pecify Yes or No-	White, etc.	10d. Inside City Limits 1 X Yes 2 No  No  nuntry?  erican Indian, Black,		
21215-0036 wild be filed within 72 hours after Mental Hygiene. marked other than "natural" c event, the Medical Examine	To Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4 or 5+) 2  Store manage  17. Father's Name (First, Middle, Last)	ation (Give kind of v e. DO NOT use reti	red)	6b. Kind of Busines			
MD 21215 dd 2 should be file nith and Mental H. nz7 is marked o aumaite event, it		William Howard Johnson  19a. Informant's Name/Relationship (Type, Print) William Johnson/brother  19b. Mailing Address (Streen Streen S						
Baltimore, Normit Pages I and Department of Health Important: If Hen?		20a. Method of Disposition  1 Burial 2 **Cremation 3 Removal from State Crematory or other place)  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of or crematory or other place)  Salisbury Crematory	ory 5/	7/09	Salisbur	Oc. Location - City or Town, State Salisbury, MD		
Physician /Medical `xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  a. Blunt Force Injuries of the Head  Due to (or as a consequence of):  Due to (or as a consequence of):	FUNETAL F. Hill Rd.,	ome Prof	essional ary, MD 2] t, shock, or heart	Association 804 Approximate Interval Between Onset and Death		
and	Medical Examiner	a.						
Box 687  he death certifi  the attending	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death but not resulting in the underlying cause			Month	Day Year		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician Exompletely filled in by the funeral director, page 2 should be detached for use as the burial.	Completed by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		2 No 3 P  24b. Were prior t death			
25. Was case referred to medical examiner?  1 Ves 2 No  25. Was case referred to medical examiner?  1 Ves 2 No  26. Place of Death (Check only one)  27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury  28d. Describe how injury occurred  3 Subject beaten  28f. Location (Street and Number or or Town, State)  1000 Beglan Park Apt. 104, Sali  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as and manner stated.								
Divis  He Hospital or A in 24 hours after the Funeral Direct pletely filled in b	Subject beaten    20							
To the Hos within 24 h	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  May 3, 2009  30. Na/ne and address of person who completed cause of death (Item 23a)						
OCME	ate	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street,  31. Date filed (Month, Day, Year)  MAY 0 8 2009	Baltimore, MD	21201				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Jenkins **Physician** Doris Mae 04 - 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Salisbur Wicomico oastal Hospice at the If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🕱 F 05/23/1926 215-20-0986 Maryland 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Maxical Evan in a sust by notified at 1 ☐ Yes 2X No Salisbury Director Maryland Wicomico 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21804 USA 302 Pineway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white \$ 3 ₩ Widowed 4 Divorced Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Catherine Parsons William Arthur Disharoon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 16133 Whitesville Rd., Delmar, DE 19940 Robert J. Jenkins/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory
Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/9/09 Hebron, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Se grentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 🗆 Nursing Home 5 🗆 Residence 1 Yes 2 No 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

Date

08

Régistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 0815 **Physician** Edward James Sr. Charles May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner HICOMICO 59115641 MIDICAL REGIONAL TENINSUM Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days 1 M M 2 □ F Months 214-36-5091 Maryland March, 28 1937 Director Usual Residence of Decedent 10d Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h County 28a-f show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner and the mathe 1 ☐ Yes 2 🗹 No by Funeral Director SomerseT Marion Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21838 5492 Bivens 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ☑No 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Md. State Highway Dept. Driver 12 tu grade

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James and 2 should be Harris Julia Frances El wood ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Barbara Ann James - wife Marion Station, Md. 21838 Bivens 5492 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Marion Station, Md. Mt. Peer V.M.c. cemetery 5-12-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Pacility Anthony E. Ward funeral Home 21. Signature of Funeral Service Licensee Princess Anne, md 21853 ٤, Ave, 30639 Hampden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Du yo (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cauce. E. Is Tordanylog Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Month Day Year signed by the atte 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗌 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate has 2 No 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 1-1200 G 24 e and address of person who completed cause of death (Item 23a) (Type, Print) 1346 32. Registrar's Signature 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May Day 2009 ear 10:54P.M **Physician** Jay KOBRIN Barry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth 9. Birthplace (State or Foreign Month, Day 9'ear) 1957 New York If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 52 Yrs. 5. Social Security Number Sex 1X M 2 □ F **Funeral** Months Days Hours Min 120-48-3077 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location s 23a or 28a-f show ust be notified at Silver Spring 1 ☐ Yes 2 ☐ No Montgomery MD Director 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 20902 710 Horton Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? r than "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: White ò 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Inc. M. once. Johns Hopkins Biologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sally Chrystowska **Emanuel** Kobrin ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 710 Horton, Dr., Silver Spring, Md. 20902 19a. Informant's Name/Relationship (Type. Print) Carol Kobrin / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Eretz Hachaim Cem. 20c. Location - City or Town, State 20a. Method of Disposition 10 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May7,2009 Bet Shemesh, Israel 22. Name and Address of Facility Torchinsky Rebrew Funeral Home 21. Signature of Funeral Service License 254 Carroll St., NW, Washington, DC 20012 Mek 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Physician Due to (or as a consequence of): /Medical Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine tencing physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No ed by the detached 9 Unknown 9 T I Inknown signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ...
autopsy
performed?
ves 2 ANo certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, n 24 hours after death.

Be Funeral Director: A pletely filled in by the fu death. within 2

the Maryland

Baltimore, Maryland 21215-0036

1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of co 5.4.2009 D24348

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd., Silver Spring, MD 20910 Steve Grufferman, MD

31. Date filed (Month, Day, Year)

MAY 08

32 Registrar's Signati

Medical

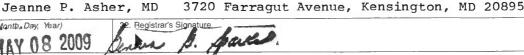
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 11:32 p<sup>M</sup> David Sjodahl 2009 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 3333 University Blvd., Kensington Montgomery West, #1001 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F June 20, 1917 Utah 528-20-8049 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Madical Examiner must be rediffied at any Injury or other traumatic event, I've Madical Examiner must be rediffied at any Injury or other traumatic event, I've Madical Examiner must be rediffied at any Injury or other traumatic event, I've Madical Examiner must be rediffied at any Injury or other traumatic event, I've Madical Examiner must be rediffied at any Injury or other traumatic event. 10a, State 1 ☐ Yes 2X ☐ No Director Kensington Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 USA 3333 University Blvd. West, #1001 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. House of 5+ Congressman Representatives 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ William Henry King Vera Siodahl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3333 University Blvd. West, #1001, Kensington, MD 20895 Rosalie L. King/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 9, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2009 Rockville, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. MD 20901 500 University Blvd. W., Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician years a Multi-Infarct Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): 68760 Physician/Medical use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. the detached 9 I Inknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate | 1 ☐Yes 2 🛣 No 1 ☐Yes 2 ☐No Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 T Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Attending 1 X Natural 5 Pending al or Attendir s after death. Il Director: Al 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. one)

iC

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and



ddress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D34032

29d. Date signed (Month, Day, Year)

May 7, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician DEBRA** MAY 2009 9:10 A Α. KEARSE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 ▼ F Months Days Director 57 MAY 19, 1951 WASH. 578-66-6288 D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director D.C. NONE WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or Funeral 500 51st. ST. S.E. 20020 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 Widowed 4 Divorced BLACK 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) FED. GOV'T. 12 ADMINISTRATIVE ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be lealth and Mental is marked GORHAM ဂ္ CHESTER DEBRA ANN WEEKLY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i CATHERINE R. THOMAS/DAUGHTER 4947 WEALDING WAY, OXON HILL, MD. 20745 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 15-8-2009 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. anders MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as e consequence of): Examiner BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed END STAGE CIRROSIS Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒No 23d. Date of delivery 3 - Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1☐Yes 2√ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending investigation nours after death. 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records,

Box 68760.

P.0.

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral D

State

29a Certifier

(Check only one)

29b. Signature and title of certifier

Medical

and address of person who completed cause of death (Item 23a) (Type, Print) OPHNELL CUMBERBATCH, M.D. 31. Date filed (Month, Day, Year)

08

3001 HOSPITAL DR., 32 Registrar's Signature

and manner stated.

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

CHEVERLY,

MD.

29d. Date signed (Month, Day, Year)

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			1 - State Registrar			Certifica					g. No. 2 1	19	1652	
	Dharis		1. Decedent's Name (First, Middle, I	Last)						ate of Death		Year	3. Time of Death	
	Physici /Medi		Richard C. Ki	dwell					Ma		4_ 20		0356 <sup>M</sup>	
	Examir		4a. Facility Name (If not institution, g	give street and number)		4b. City	, Town, o	r Location of De	eath		4c. County o	f Death		
Í	Funeral Director		579-36-3050	land Hospi Sex 7. Age (	tal (In yrs. last bii 77		lint er1Year Days	If Under 24 Hours M	lin. Fe	ate of Birth Jonth, Day,	Princ 1932	9. Birthpl Coun D. C	Porge's lace (State or Foreign try)	
	and w		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Tow	n or Location						10	Od. Inside City Limits	
	he Maryl 28a-f sho	Director	MarylandPrince  10e. Street and Number			er Marl		0	***************************************	140	03:		1 ☐ Yes 2 No	
	with with the sa or	Ö	3403 Asher St			101. 21	p Code 207	72		10	g. Citizen of Wh		tr <b>y</b> r	
	eath	Funeral	11. Marital Status	12. Was Decedent Eve	er in II S	13 Was Dece			(Specify Y	es or No-	US.		an Indian	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evaminar must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		If Yes, spe		Hispanic Origin? an, Mexican, Pu Specify:	uerto Rican,	etc.)		White, e	etc.	
9-0	2 ho	ted	15. Decedent's (Specify only highest of	Education	16a	. Decedent's Usu	ual Occup	oation		11	6b. Kind of Bus	iness/Ind	lustry	
215	thin 7 le.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of wo life. DO NOT L	ork done use retire	during most of t d)	working	.']' [	Depart	ment	of	
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nd	be filk tal H d oth even	Be	17. Father's Name (First, Middle, La					18. Mother's I	Name (First	t, Middle, Mi	aiden Surname	) -		
\\	ould Mer narke	မ	Richard I. Kis					L.,.		Doug				
la l	2 sh h and ris m		19a. Informant's Name/Relationship		195	3 4 ding Addres	sher	and Number of	r Rural Rou	te Number,	City or Town, S	tate, Zip	Code)	
e)	l and Healt		Brenda William			103 As			Date		oc. Location - C			
Saltimore, Maryland	iges if ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Li nemovar nom State	ĺ	Disposition (Na ry, crematory or		i			uc. Location - C	ity or to	wn, State	
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Ba	permi Depa Impo any Ir		21. Signature of Funeral Service Licensee  White Name Reddies of Each Sons Mortuary, P.A.  821 West St. Annapolis, Md. 21401											
					ne death Do							2120	Approximate	
68760,	eath certificate be executed attending physician and attending physician and for use as the burial-transit	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, mmediate Cause (Final disease or condition esulting in death)  a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  Due to (or as a consequence of):									Interval Between Onset and Death		
P.O. Box 68	Physician: The law requires that the death certificate be this certificate has been signed by the attending physicia rail director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1  Live birth 2 4  Pregnant at ti 9  Unknown	Fetal death	n 3 🗆 Ectopic 5 🗆 Other (s		су			23d. Date Mon		ery Day Year	
	v requires that the de been signed by the a should be detached for	by	Part II. Other significant conditions	s contributing to death but i	not resulting i	n the underlying	cause giv	ven in Part I.	_ 2				ne cause of death? pably 4 🗆 Unknown	
Reco	ilcian: The law re certificate has ber rector, page 2 sho	Completed	gar-color-dam-com-						-   -	4a. Was an autopsy perform	pr legi? de	ere auto for to core eath?	psy findings available mpletion of cause of	
ita	lan: rtifica stor, p	a)	25. Was case referred to medical					26. Place of			-		2 🗆 140	
<b>&gt;</b>	nysic alis ce direc	o B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2X ER/O	utpatient 3 🗆 D	Oth	ner: 4 🗆 Nursin	ng Home	5 ☐ Resider	nce 6 Othe	r (Specif	·y)	
0 4	iling Phys n. After this funeral di	Ë.	27. Manner of Death	28a. Date of Injury (Month, Day.)	28b.	Time of Injury	28c. Inju Wor	ry at			w injury occurre			
Division of Vital Records,	To the Hospital or Attending Physician: The law requii within 24 hours after death.  To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should	Certification: To	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)								r or Rura	d Route Number,		
_	e Hospitai 24 hours e Funeral	Medical C	29a. Certifier (Check only one)  Certifying  Certifying  Medical Ex	Physician: To the best of aminer: On the basis of e and manner state										
	ompl	Me	29b. Signature and title of certifier			29	c. Licens	se number		29	d. Date signed	(Month <sub>y</sub>	Day, Year)	
	101	0	1 4 000-	~ ,0			N	405	-5-	Ċ	05/0	4/	Day, Year)	
	ORD		30. Name and address of person wh	no completed cause of dea	ith (Item 23a)	(Type, Print)	NU	,,00	)			•		
•	~ /Z		ERTO Mel	onald 7	503	SURR	at	ts Rd	C1.	ato	e Md	20	3735	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pegistrar's	s Signature		-7 /				1			
	Registi	ar	MAY 07	2009 Duna	_ A.	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:10 P. 2009 Mildred E. Knight May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Larkin Chase Nursing Home Bowie Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** Months Days Hours 1 □ M 2**XX** Rockhill, Yrs July 13,1919 S.Car 89 Director 138-07-9458 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State show ed other than "natural", or items 23a or 28a-f show event, the Medical Evanither must be notified at 1 ⊠Xes 2 □ No South Plainfield Middlesex Director N.J. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with U.S.A. 07080 215 Cedarbrook Avenue Funeral within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2\lambda No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 □Yes 🎞 No Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mean Injury or other traumatic event, the Means Injury or other traumatic event, College (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josie Belle Kennedy Joseph Massey ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 215 Cedarbrook Avenue, So. Plainfield N.J. 07080 Barbara Cooke/ daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Hoboken North Bergen, 1 

Burial 2 □ Cremation 3 □ Removal from State 5/9/2009 New Jersey 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Fuperal Service License 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1)emeni resulting in death) /Medical Due to (or as a consequence of) dney disease Examiner MOMIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 □Yes 1 ☐ Yes certificate 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **M**o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: ₽ 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide

P.O. Box 68760, Division of Vital Records,

> Medical completely within 2. Registrar

29a. Certifier

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and address of person who completed cause of death (Item 23a) (Type, Print)

avaKoli 12200 Annapolis

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene)

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 Year Physician 8:50 A M May 8, Sarah Knowlton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 17320 Quaker Lane #B20 Sandy Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 8, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 □ M 2 🛛 F New York 006-30-7205 1933 75 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show event, the Medical Examiner must be nufflied at 1 ☐ Yes 2X No Directo MD Montgomery Sandy Spring death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō or items 23a 20860 USA 17320 Quaker Lane #B20 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ā No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Healthcare permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygiens important: If Item 27 Is marked other the any injury or other traumatic event, In. 8 once. Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Louise Davis Paul Holland Knowlton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5355 Hesperus Drive Columbia, MD 21044 Holly A. Thompson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 05/09/09 Odenton, MD 21. Signature of Funeral Service Licens Common Homes Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancreatic Cancer 1 year resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician; The law requires that the death certificate be executed physician as the burial-t Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 st autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death.

Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours e Funeral 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hour To the Fune completely fi Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifie 29c. License number May 8, 2009 (Das) nd address of person who completed cause of death (Item 23a) (Type, Print) Garrett Reilly, M.D. 3418 Olandwood Court Suite 111 Olney, MD 20832 31. Date filed (Month State Registrar

Certificate of Death

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland

Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be exe within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial-
2	3A
DH	St Regis

Q		Decedent's Name (First, Middle, Last)				2. Date of De	ath Day	Year	3. Time of Death
Physici /Medic		Edna Katherine Kirkwood				May	6	2009	2:35 P M
Examin		4a. Facility Name (If not institution, give street and number) Golden Living Center		4b. City, Town, or I Westminst				croll Co	ounty
Funeral Director		5. Social Security Number 215–32–0716 6. Sex 1 M 2 F 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 26	h V. Year) 192	9. Birthp Cour 24 Maryl	lace (State or Foreign and
fshow	tor	7	, Town or Lo					11	0d. Inside City Limits 1 ☐ Yes
3e or 28a	ai Director	10e. Street and Number 19701 Grave Run Road		10f. Zip Code 21074			-	en of What Coun	•
Department of Health and Mental Hygiene. Importent: or Items 23e or 28a-f show Importent: If item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other treumatic event, the Madical Examinational Local Additional Once.	by Funerai	11. Marital Status  1 X Never Married 2 Married 3 Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2X No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
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ental Hygie ked other t c event, In	To Be Co	17. Father's Name (First, Middle, Last) Franklin L. Kirkwood			18. Mother's Name Hilda A	-	Maiden S		
alth and M 27 is mar er treumati	_	19a. Informant's Name/Relationship (Type, Print)  Corrie Sanders – niece		ng Address (Street and 17 Grave R			-		nd 21074
nent of He ent: If iterr ury or oth		C6	metery, crei	osition (Name of matory or other place Cremation	May 200		Hamp		own, State Maryland
Departi Importi any inj		21. Signature of Funeral Service Licensee M010	72 93		lain Stre	et Han	pstea	Home ad, Mary	land 21074
nysician Medical		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequ	teric					O	Approximate Interval Between Onset and Death
ician and purial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	lum	Dollar	semu	Nes	lare		Imor 10 cm
the attending physician and ned for use as the burial-transit	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   22 No 9   Unknown   Unkno	death 3	□Ectopic pregnancy □ Other (specify)			23	3d. Date of delive	ery Day Year
signed by	d by Physi	Part II. Other significant conditions contributing to death but not resu	ulting in the u	inderlying cause give	n in Part I.	23e. Did 1			he cause of death?
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urs after oral Direction		4 Homicide determined building, etc. (Specify	·)			City or To	wn, State)		
the Fune	Medical	29a. Certifier (Check only one)  1			inion, death occur		date and		o the cause(s)
F C S	-	29b. Signature and title of certifier.	nD	D 25	443		5/6	/2009	<i>y</i>
3		30. Name and address of person who completed cause of death (Item Tom W. M. M. Addition M. B. 3337	Victo	ry Stree	+ ma	nchest	ta n	10 21	102
Sta Regist		31. Date filed (Month, Day, Year)  MAY 0 7 2009  Service A		elle !			,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 8:52 A 2009 9, ROBERT HENRY KEENE, III May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerset McCready Memorial Hospital Crisfield If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) January 5, 1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 ₹M 2 □ F 73 216**-**34**-**2711 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State show r 28a-f show notified at 1 ☐ Yes 2 ☑ No Maryland Somerset Westover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a or 21871 8781 Wedda Scott Road USA Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene.
Instit if item 27 is marked other than "natural", or thems 23, mirt if item 27 is manded other than "natural", or theme must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Trucking Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Hays Robert Henry Keene, Jr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 8004 Oakleigh Road - Baltimore, Maryland 21234</u> Robert Lee Keene (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any Injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory May 11, 2009 Salisbury, Maryland 21. Sign way Funewal Sey Full ensure Mary beth bradshaw 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ng physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by Comi o ma 1 | Yes 2 | No 3 | Probably ♥ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2X No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner's 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA ۴ After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 2 ☐ Accident 5 Pending investigation (Month, Day Year) Injury To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D15715 May 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u> 26423 Burton Avenue - Crisfield, Maryland 21817</u> William Gill, M.D. State Registrar

			For State Registrar	State	of Marylar	nd / Depa	artment of H	lealth an <i>Death</i>	d Men		ene () (	9	16626
			Decedent's Name (First, Middle)	, Last)						Date of Death			3. Time of Death
	Physici		JULIA CLAI	RE LINI	DERMAN					Month IAY 6	Day 2	Year 009	6:50 A M
)	/Medic Examin		4a. Facility Name (If not institution	give street and n	eet and number) 4b. City, Town, or Location of De			eath	4c. County		of Death		
			Genesis Health	Care Layl	e Layhill Center Silver Spring		ng		Mon	tgom	ery		
	Funeral Director		5. Social Security Number 579-40-0885	6. Sex 1 □ M 2 🕱 F	7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 Year Months Days		Min. (	Date of Birth Month, Day, Y		Coun	lace (State or Foreign htry) ington, D.C.
	D .		Usual Residence of Decedent		40.0	-							
	arylar ehow	_	10a. State 10b. County		10c. Ci	ity, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 No
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n D	permit. Departr import eny inj	i s	John Cunt	1	00470		Muriel	H. Bark Box_503	per Fu	ıneral aytonsv	Home	Md.	20882
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	th. Do not ent	er the mode of dyir	ng, such as car	rdiac or res	piratory arres	t,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):							
	Examine	Examiner	Sequentially list conditions, if any, leading to immediate	b	/25 22 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2								
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	al-trar	xan	that initiated events resulting in death) Last	c. Due to	o (or as a consec	quence of):						$\rightarrow$	
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9	flicate g phy as the	edic		U									
O. 50x	The law requires that the death centificate be executed ite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	1 Live	utcome of pregn birth 2 Feta gnant at time of a nown	aldeath 3□	Ectopic pregnanc Other (specify)	y			23d. Date Mor		ery Day Year
T.	s that ned by deta	by Ph	Part II. Dther significant condition	ns contributing to	death but not re:	sulting in the u	nderlying cause giv	en in Part I.		23e. Did toba	cco use contr	ibute to th	ne cause of death?
cords,	equire; en sig		Pneumonia						[	1 🗆 Yes	2 🗆 No	3 Prob	pably 4 Unknown
		Completed							-	24a. Was an autopsy performe 1 ☐ Yes 2 ☐	ed? d	Vere auto rior to co eath? Yes	psy findings available mpletion of cause of
	certifi	Be	25. Was case referred to medical examiner?	Hospital:			O#	-		eck only one)			
5	Phys ratdi	2	1 Yes 2 No 27. Manner of Death	11		ER/Outpatier 28b. Time of	I 3L DOA	4 🖂 Nursii		5 Resident			y)
5	th. Afte	tlon	1 Natural 5 Pending 2 Accident investig	9	of Injury nth, Day Year)	Injury	Wo	rk? Yes 2⊟No	200.		injury coours		
	To the Hospital or Attending Physician: which 24 hours after deals after deals. To the Funeral Director: After this certifica completely filled in by the funeral director.	ertification:	3 Suicide 6 Could r 4 Homicide determ	at he	e of Injury - At h ding, etc. (Speci	nome, farm, str ify)	eet, factory, office		28f.	Location (Stre City or Town,	et and Numbe State)	er or Rura	al Route Number,
	Hospit. 24 hours Funera	edical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the	ne best of my knobasis of examination	owledge, death ation and/or in	n occurred at the tr vestigation, in my o	me, date and p opinion, death o	place, and o	due to the cau t the time, date	se(s) and ma e and place, a	nner as s and due to	tated. o the cause(s)
	o the o the	Med	29b. Signature and title of certifier		illior stated.		29c. Licens	se number		290	I. Date signed	(Month,	Day, Year)
	⊢ ≱ ⊢ ŏ		D0064208 May 6, 2009										
			30. Name and address of person	who completed car	use of death (Ita	m 23a) (Tyne							
			Saadia Husain,	M.D.	3227 B	el Pre	Road, S	ilver S	Sprin	g, Md.	. 2090	06	
	Sta Registr		31. Date filed (Month, Day, Year)	8 2009 32.	Registrar's Sign	ature A. A	parke						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend 24-29 per Dr. g891 5/22/10/9cate of Death 2. Date of Death

59

10d. Inside City Limits

1 ☐ Yes 2√ No

Maryland

white

21204

Approximate Interval Between Onset and Death

Day

Year

21204

**Physician** /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat has be notified at once.

Saltimore, Maryland 21215-0036

Physician ) /Medical Examiner

law requires that the death certificate be executed burial-transi and physician the t attending pl the detached signed by to icate has been si, , page 2 should b certificate director, within 24 hours after death.

To the Funeral Director: After this funeral c Hospital or Attending

the

filled in by

To the }

Box 68760

P.O.

Division of Vital Records,

1. Decedent's Name (First, Middle, Last) Day Month 2009 Aiden Lewis March 24, 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center <u>Baltimore</u> Towson Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Mar 24, 20 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Days Months 1**X** M 2□ F Hours 2009 infant Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County MD Harford Abingdon Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 423 Greentree Circle 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify: <u>Ş</u> 3 DWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Craig Lewis Jessica Davis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6701 N. Charles Street Baltimore, MD Greater Baltimore Medical Ctr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 10 Other (Specify) in state 22. Name and Address of Facility 21. Signature of Juneral Structures S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 150m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? X 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. #406 Balto MD 565 Hunter, -illian

State Registrar

31. Date filed (Month, Day,

Year)

32. Registrar's Signature

23a or 28a-f show

event, the Modical Examiner must be notified at

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"natural", or items

al Hygiene.

physician and s the burial-trans

attending p

detached

funeral

filled in by

To the Hospital within 24 hours a To the Funeral C

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Completed

Be

Certification: To

Medical

1. Decedent's Name (First, Midd

State of Maryland / Department of Health and Mental Hygiene

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	Ce	ert	ific	ate	of	D	eat	th	1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-	Reg. No	0	0	9	
o of Do	ath				

10g. Citizen of What Country?

Year

fle, Last)			2. Date of Death			<ol><li>Time of Death</li></ol>
,,			Month	Day	Year	7:29 ам
Mary Louise	Morton		April_	29	2009	7:29 a W
on, give street and number)		4b. City, Town, or Location of Death		4c. Co	unty of Death	

cinty Name (ii not institutio	iri, give sireer and m	uiiiDeij	4b. Oity, 101111, 01	Eddation of Dourn		ioi obaini, oi boaini		
Villa Rosa Nurs				chellville		ince George's		
cial Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Year)	9. Birthplace (State	

 Birthplace (State or Foreign Country) 1 □ M 2 🕮 F April 28, 1919 New York 077-16-2656 90 Usual Residence of Decedent

10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 1 □Yes 2 No Mitchellville Maryland Prince George's

3800 Lottsford Vista Road 20721 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 k No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 16b, Kind of Business/Industry

10f. Zip Code

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Religious of the Eucharist Religious Sister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

William Engleman Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print)

Robin M. Oliver - Personal Rep. 12401 Kenbridge Drive, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition

1 ■ Burial 2 □ Cremation 3 ■ Removal from State Mt. Olivet Cemetery 05/04/2009 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC

22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc.

11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease of camplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final

9 Unknown

**Years** Atherosclerosis

disease or condition resulting in death) Due to (or as a consequence of):

Years General Debility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Alzheimer's Dementia Years

Examiner Due to (or as a consequence of): Physician/Medical

IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Day Month in the past 12 months? 5 ☐ Other (specify) 4 ☐ Pregnant at time of death Tyes 2 No.

9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🛣 No

3 ☐ Probably 4 ☐ Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 🗷 No 1 ☐ Yes

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident

6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Nurse Practitioner (Check only one)

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

R068482

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Millie Jarrell, CRNP, 14300 Gallant Fox Lane, Suite 222, Bowie, Maryland 20715

31. Date filed (Morith, Day, Year) 32 Registrar's Signat MAY 08 2009 Registrar

			FoAmend#8per FH State of Maryland / I 1- Registrar 5/11/09 AACO HEALTH DEPT. CMH	Department of Health and Certificate of Death	d Mental Hygie Reg.	
			Registrar 3/11/09 AAO HEALTH DEPT. (NH  1. Decedent's Name (First, Middle, Last)	Octimodic of Bodin	2. Date of Death	3. Time of Death
	Physicia				Month	Day Year 12:35P M
aring .	/Medic Examin		Louis McGowan, Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Death
-1.	LXaiiiii		South River Health & Rehba.	Center Edgewa	ter	Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year   If Under 24 H	Hrs. 8. Date of Birth Min. (Month, Day, Ye	1932 9. Birthplace (State or Foreign Country)
ш	Director		218-26-2918 <sup>1</sup> X <sup>M 2□ F</sup> 73	Yrs.	July 12	1935 Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
	daryli f sho	ō	Maryland Anne Arundel Anna	polis		17⊈Yes 2 □ No
	the f	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	h with		222 Croll Dr.	21401		USA
	deat ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin if Yes, specify Cuban, Mexican, Po	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	be filed within 72 hours after death with the Maryland rial Hygiene.  ad other than "natural", or items 23a or 28a-f show event, I'm Marical Examiner must be notified at		1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 2 Never Married 3 Never Married 1 Neve	1 □Yes 2 <b>X</b> No Specify:	,	Specify: Black
21215-0036	2 hou atura cal E	Completed by	15. Decedent's Education 16a	a. Decedent's Usual Occupation		b. Kind of Business/Industry
21	within 7; iene. • than "n	edr.	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of life, DO NOT use retired)	working	
2	ed wit	ပ္ပ	12th 0	Heating & Oil		napolis Utilities
pu	be filed v ntal Hygie ed other t event, th	Be	17. Father's Name (First, Middle, Last)		Name (First, Middle, Mai	
yla	2 should be and Mental Is marked raumatic ev	욘	John McGowan	Nola b. Mailing Address (Street and Number of	Unobtaina	
Mai	nd 2 sh alth an 27 Is r r traur			22 Croll Dr. Ar		
آ	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic			of Disposition (Name of ery, crematory or other place)		c. Location - City or Town, State
Baltimore, Maryland	ages ent of nt: If i		1 LX Burial 2 LI Cremation 3 LI Removal from State		5-7-09 C	rownsville, Md.
푩	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	Maylame Buchyapase of Bacilia2 C	and the second	
m	permi Depa Impo any ir		Jany A. Reese BOSE83	821 West St. A		
			23a, Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as car	rdiac or respiratory arrest	liller var betweett
-	Physician			Jerotic Cardi	o vascula	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence			
	Exammen	<u>.</u>	Sequentially list conditions. b.	- A		
	ted 1sit	Examiner	if any, leading to immediate cause. Enter Inderlying Cause, Disease or injury	oij.		
_ in	execu al-trar	xar	that initiated events c	of):		
8760,	icate be executed physician and the burial-transit	dical				
	tificat ig phy as the	ledi				
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat	h 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
Э. П	ires that the death certificing isigned by the attending is be detached for use as	Physician/Me	in the past 12 months?  1	5 Other (specify)		MOILII Day real
P.0.	hat thed by detack	Ph/	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
rds,	quires t n signe	d by		enal Failure	1 🗆 Yes	2 No 3 Probably 4 Unknown
eco	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Completed by	Anciemice	4.5	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E H	sician: The law certificate has b irector, page 2 s	Cou	Penipheral Arterial	disease	performe 1 □ Yes 2 L	d? death? ☑No 1 ☐ Yes 2 ☐ No
Σ Σξ	Physician: r this certific ral director,	a	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor	Death (Check only one)	
ot	Phys r this ral dii	1.70	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at	ng Home 5 Residence 28d. Describe how	
on	ding th. Afte fune	ţi	1 ☐Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury Work?  M 1 □ Yes 2 □ No		•
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 Hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, 1 building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	oital o		29a. Certifier 1 Certifying Physician: To the best of my knowleds		place and due to the cou	and manner as stated
	To the Hospital within 24 hours a To the Funeral C completely filled	ledical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death	occurred at the time, date	e and place, and due to the cause(s)
	Vithin To the comp	Me	29b. Signature and title of certifier	29c. License number		I. Date signed (Month, Day, Year)
	.1.1	D	Layar c. sur	ana D 5065	75	5/5/09
	1x Op		30. Name and address of person who completed cause of death (Item 23a	(Type, Print) GYAN .	G. Curi	ANA
	1/2		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Hon Road	Deale	mp 2075)
	Sta Registr		MAY 07 2009	back		

DHMH 17 Rev 1/2001

State Registrar

Amended Item 18 per F.D. 05/06/2009 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1538 ENVIS 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 8. Date of Birth (Month, Day, Y Mar 11, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign <sup>Yea</sup>r) 1943 **Funeral** Days Months Hours 1**X** M 2□ F 383-42-4986 66 Michigan Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r 28a-f show 1 ☐ Yes 2 No Westminster Director Carroll Maryland the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 2 and hyliging or other traumatic event, the Medical Examiner must be reported. 21158 1404 Warehime Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Commercial Plumbing Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Szymonski Ruth Szymanski Ernest Joseph Meloche ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Warehime Road, Westminster, MD 21158 Maureen Meloche, wife 20b. Place of Disposition (Name of Society, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 5/6/2009 Winfield, MD Carroll Crematory 4 Donation 5 Dother (Specify) Stanature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Parth Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** schemic year 5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t oletely filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Greenest. Bultimore MD 21201 MVKI

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 06

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** RACHEL KATHERINE McCREADY May 4, 2009 3:03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care - Rossville Baltimore County Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 KF 217-16-9798 93 June 29, 1915 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The matural", or items 23a or 28a-f shou any Injury or other traumatic event, the Medical Exemiter must be notified at once. Maryland Baltimore 1 ☐ Yes 2 ☑ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3673 Double Rock Lane U.S.A. 21234 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Riggin Ida Mae Ward ۴ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolee Freeze (Daughter) 3673 Double Rock Lane - Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Memorial Park 5/9/09 Crisfield, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Robert H. Bradshay Jr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMENTIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ cate has been si page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Attending Physician; The certificate 2 100 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation **1** ☐ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) -ILANETHHA PS TERPAL 106 -Eb 10 32 Registrar's Signature 31. Date filed (N State Registrar

			For State Registrar	State of Ma		partment of F ertificate of		-	giene Reg. No. 20	09 16633
			Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	Physicia		Francis Lee	Martin				Month	Day	Year 2125 M
£ .	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death		4c. County	.00
and the			Salisbury Rehabil	itational	lussineCt	r. Sa	lisbur	4	Wi	icomico
	Funeral		5. Social Security Number 6. Sex	7. Age	(III yis. last <del>bi</del> llilli	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th l <i>y, Y</i> ea <i>r)</i>	9. Birthplace (State or Foreign Country)
	Director		227-36-2823 Usual Residence of Decedent	\"	81 Yrs			07-06-1	1928	Virginia
	land ow		10a. State 10b. Counfy		10c. City, Town or	Location				10d. Inside City Limits
	Mary If sh	to	MD Wicomico		Salisbur	v				1 Yes 2 □ No
	or 28s	Director	10e. Street and Number		Dalibbai	10f. Zip Code			10g. Citizen of	What Country?
	th wit		201 Sandy Bottom	Court		218	04		USA	A
	r dea	Funeral	A	Was Decedent Ev Armed Forces?	ver in U.S. 1	<ol> <li>Was Decedent of H If Yes, specify Cub.</li> </ol>	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Ra	ce - American Indian, ack, White, etc.
30	hours after death with the Maryland tural", or items 23a or 28a-f show at Examinar mast be rediffed at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 ☐ No If Yes, Give		1 □Yes 2 <b>X</b> No	Specify:		Specia	fv.
215-003b	I within 72 hours after death with the Marylan jene. r than "natural", or items 23a or 28a-f show the Majical Examinatings the relifted at		15. Decedent's Educ	Year or Dates: 1		cedent's Usual Occup	ation		16b. Kind of B	White Business/Industry
<u>က</u>	within 72 iene. than "na"	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+	(G	ive kind of work done e. DO NOT use retire	during most of wor	king		,
7	d with giene er tha	ĕ	12	none		pervisor			Telepho	one Company
9	be filed ntal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan			ne)
<u> </u>	2 should be and Menta Is marked a	2	James Martin				Mable Ir			
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ee once.		19a. Informant's Name/Relationship (Type Beatrice B. Marti			ailing Address <i>(Street</i> Sandy Bott				
altimore,	is 1 and of Height Item		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other place	ce)	Date	20c. Location	- City or Town, State
Ē	Page nent o		1  Surial 2  Cremation 3  Re  4  Donation 5  Other (Specify)	emoval from State		ood Cemete		3/2009	Princes	ss Anne, MD
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			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused t e cause on each line	he death. Do not	enter the mode of dyi	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
<u></u>	Physician		Immediate Cause (Final disease or condition resulting in death)	De	men	la				gears
٪ د	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					(
	od ansit	Examiner	Sequentially list conditions, if any, leading to immediate access. Exercit underlying Cause (Disease or injury that initiated events							
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٥	ertific ling p e as t	Mec	IF FEMALE:							
X R R	death certific e attending p d for use as t	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o	Fetal death	3 Ectopic pregnand	у		I .	ate of delivery Ionth Day Year
j		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time or death	5 ☐ Other (specify) _				
7.	that ned by deta		Part II. Other significant conditions con	tributing to death but	not resulting in th	e underlying cause giv	en in Part I.	23e. Did	tobacco use cor	ntribute to the cause of death?
VItal Records,	requires that the reen signed by th rould be detache	d by						1 🗆	Yes 2. ₩o	3 Probably 4 Unknown
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ř	The late has	mo						auto perfo 1 □Yes	psy ormed? 2 □ No	death? 1 ☐ Yes 2 ☐ No
<u> </u>	slan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only	one)	
2	hysic this ce al dire	မ	1 ☐ Yes 2 ☐ HO		nt 2 ☐ ER/Outpa	tient 3 DOA Oth	ner: 4 Nursing H	lome 5 ☐ Res	idence 6 □ O	ther (Specify)
Ĕ	After i	ion:	27. Manner of Death 1 ☑-Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	y 28b. Tim Year) 28b. Tim Inju	ry Wo		28d. Describe	how injury occu	rred
VISION	ttend death stor: / the i	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29o Place of Injur	at - At home form	M 1 Street, factory, office	Yes 2 □ No	28f Location	(Stroot and Num	nber or Rural Route Number,
<u>≥</u>	after Direction by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	Street, lactory, office		City or To	wn, State)	ber of Hural House Number,
	spita hours neral y filled					eath occurred at the t				
	To the Hospital or Attending Physician: The law within 24 hours after death.  Within 24 hours after death.  To thin 24 hours after death.  Completely filled in by the funeral director, page 2 s	Medical	(Check only 2 Medical Examir	ner: On the basis of and manner stat		or investigation, in my	opinion, death occi	urred at the time	, date and place	e, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1		29c. Licen:	se number	0	29d. Date sign	ned (Month, Day, Year)
	24		100/11/11	has		02	1) 19		2/7/	0)
	ID		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Ty	pe, Print)	5.11	shuru	My	21804
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	face				
	Registr	ar	MAY 11	2009 Jan	we p	gare				

09-03844 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Daniel Naugle 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle Last) Physician/ Month Daniel Naugle Medical Examiner May 14, 2009 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Salisbury Wicomico Peninsula Regional Medical Center If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 220-68-8613 Days Director 51 06/02/1957 2 1 X M Usual Residence of Decedent 10c. City, Town or Location iny 10a State 10h County 28a-f show Maryland Somerset Eden or items 23a or 28a-f show must be notified at ouce. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10f, Zip Code 10e. Street and Number 32794 Sea Tick Road 21822 USA 13. Was Decedent of Hispanic Origin? ( Specify Yes or No Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married Married 2X No Yes 3 Widowed 4 XDivorced If Yes. Give Yea Yes 2 X No specify: Specify: 3 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than "r 21215-0036 12 mechanic 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pete Naugle Laura Lenz is marked 19a. Informant's Name/Relationship (Type, Print ) of Health and M Jennifer Naugle/daughter 4387 Smith Rd., Salisbury, MD 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Itimore, springhill Memory 1 X Burial 2 Cremation 3 Removal from State Department o 5/18/09 Donation 5 Other Specify 21. Signature of Suneral Pervice Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician **Medical** Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner ause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 23a,27 per me g892 6-11-09 vt attending physician or use as the burial -Box 68760. IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. \$ Completed 24a. Was an autopsy has death? page 2 s performed? ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other; Hospital: Residence 6 DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 V Yes

8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or oreign Countr**Delaware** 10d. Inside City Limits Yes 2 X No 10g. Citizen of What Country? 14. Race - American Indian, Black, white 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hebron, MD 22. Molfoway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23d. Date of delivery Dav Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 1 🗸 Yes No After this certific funeral director, p To the Hospital or Attending Physiciau: Division of Vital 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural Yes 2 Pendino 24 hours after death To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number **OCME** May 14, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day 32. Registrar's Signature State Registra

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			For State Of Maryland  1 - Registrar		tificate of l			Reg. No.			
	-		Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ith	Year	3. Time of Death	
	Physicia /Medic		William W. Nott				05	07 20	09	9:35 A M	
	Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De							4c. County o			
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	Director		216-36-9964 <sup>18∑ M 2□ F</sup> 73	Yrs.	Months Days	Hours Min.	12/22/1	L935	Pen	nsylvania	
	and		Usual Residence of Decedent  10a, State 10b. County 10c. City,	, Town or Loc	eation		_	_	1	0d. Inside City Limits	
	Maryli -f sho	tor		yaskin						1 ☐ Yes 2 <b>X</b> No	
	h the	Director	10e. Street and Number	, 0.0	10f. Zip Code			10g. Citizen of W	hat Cour	ntry?	
	23a c	ral	4670 Tyaskin Rd.		21865			USA			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, If a Myclical Evair if arriving the indifficed at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S  Armed Forces?  1 □ Yes 2 ▼ No  If Yes, Give  Ye ar or Dates:		Vas Decedent of H fYes, specify Cuba □Yes 2XNo	dispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	, White,	ean Indian, etc. nite	
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/lan	uld be Menta Irked	To Be	William Nott Sr.			Machr	ee Not	t			
Mar	ind 2 sho alth and 1 27 is ma er traume		19a. Informant's Name/Relationship (Type. Print) Suk Son/spouse	19b. Mailin 46'	g Address <i>(Street</i> 70 <b>Tyask</b> i	and Number or Run in Rd., Ty	<sub>al Route Numbe</sub> yaskin,	er, City or Town, S MD 2186	State, Zip <b>5</b>	Code)	
Baltimore, Maryland 21215-0036	Pages 1 arent of Hesent: If item				sition (Name of natory or other place		Date 1/09	20c. Location - C	•		
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Division of Vital Records,	: The law re cate has be page 2 sho	Completed				-	24a. Was autop perfo 1 □ Yes	osy p emed? d	Vere auto rior to co leath? Yes	opsy findings available ompletion of cause of	
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	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical C	29a. Certifier  (Check only one)  Certifying Physician: To the best of my know one)  Certifying Physician: To the best of my know and manner stated and manner stated								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2:30a<sub>M</sub> **Physician** 2009 May 05 Dorothy Plapinger Polakoff /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Chevy Chase 8100 Connecticut Avenue, #323 Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 M 2 ■ F January 28, 1913 New York 96 Director 577-46-7660 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location sa or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2x No Chevy Chase Directo Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20815 U.S.A. 8100 Connecticut Avenue, #323 "natural", or items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify Baltimore, Maryland 21215-0036 þ White 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) University Professor 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Bernhardt Henry Plapinger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra 3202 Coquelin Terrace, Chevy Chase, Maryland 20815 Shirley P. Stein - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 x Removal from State 05/07/2009 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) Adas Israel Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service License Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, occupilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on some cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Coronary Artery Disease as the burial-tran and Division or Vital Records, P.O. Box 68760,か Due to (or as a consequence of): physician Physician/Medical attending p IF FEMALE 23d. Date of delivery If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 5 ☐ Other (specify) 4□Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes 2 No 3 Probably 4 Unknown Hypothyroid Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Osteoarthritis autopsy perform 2 X No 2 🗌 No 1□ Yes Dementia or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No 1 🔲 Inpatient Certification: To this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After Injury (Month, Day Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No r death. 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

32. Registrar's Signature

Raman Rekha Tuli, M.D., 10810 Darnestown Road, Suite 202, Gaithersburg, Maryland 20878

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1540 ™ 2009 Leroy Phillips May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Hours | Min. June 17 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Min. June 1924 1**∑** M 2□ F Maryland 213-28-9609 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Galesville Maryland Anne Arunde! 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 961 West Benning Rd. 20765 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 □Yes 2√2 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7th 0 Bernard Hallock & Co Waterman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bud Phillips Lillian Crowner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Geneva Ballard(Fiance)</u> 961 West Benning Rd. Galesville, Md. 20765 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer AME Church 5-7-09 | Galesville, Md. 21. Signature of Funeral Service Licensee Winhame Redesse of Reiliosons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MOS Due to (or es a consequence of) Sequentially list conditions, if any leading to in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

**Examiner** 

Directo

Funeral

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Completed

Be ၉

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Wolfier Examples to Little 4 and once.

Saltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-transit Physician/Medical signed by the a d be detached fi s certificate has been s irector, page 2 should Completed nin 24 hours after death.

the Funeral Director: After this certific

mpletely filled in by the funeral director, Be ၀ Certification:

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Hospital or 24 hours a

To the within 2

23b. Was decedent pregnant

27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

5 ☐ Pending investigation

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

elouil, a

29c. License number
D 19 838 e. Printo Bestgate Rd. Annapolis, Md.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

selonial, mo 32. Registrar's Signature

Registrar

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		1	For State Registrar		State	of Mar	ylan		artmer rtificat			and M	lental Hy	gienę Reg. No	000	9	16	638	
			1. Decedent's Name (First,	Middle, Las	st)								2. Date of De	ath Day		ear	3. Time	of Death	
Phys /Me	sician edica		Soon Bok B	aek									Мау	77,	2009	eai	6:5	0 P M	
e.	mine	•	4a. Facility Name (If not inst	itution, give	e street and n	umber)			4b. City,	Town, or	Location of	of Death			County of				
			5102 Parklaw	m Ter	race #				Rock			****			ntgor				
Fune Direct			5. Social Security Number 215–33–8986		ex □м 2 <b>X</b> 1 F	7. Age	(In yrs. l	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da May 10	ay, Year)		Count	ace (State ry) orea	or Foreign	
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after after Dire	, itiootisis	ב ק	4 ☐ Homicide	letermined	buil	ding, etc.	(Specify	y)					City or To	wn, State,	)				
To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	looi	Medical	29a. Certifier (Check only one)	rtifying Ph dical Exar	nysician: To the	ne best of basis of e	examina	wledge, deat tion and/or in	th occurred	at the tin	me, date a	nd place, ath occur	and due to the red at the time	e cause(s) , date and	and man place, an	ner as s id due to	tated. the caus	e(s)	
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(3)00	•		Yoon J. Cho	, D.O	. 5576	-B No	orbe	ck Roa	d Ro	kvil	lle, 1	MD 20	0853	_					
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 30 PM Anne Phipps 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death tho 5) mo) lu Social Security Number 6. Sex 7. Age (In yrs. last birthday) 77 Yrs. Under 1 Year | If Under/24 Hrs 8. Date of Birth (Month, Day, Year) 09/21/1931 9. Birthplace (State or Foreign Months Days Hours Maryland 1 □ M 2 🛣 F 214-32-5638 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 X Yes 2 ☐ No Wicomico Salisbury Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21801 IISA 526 S. Pinehurst Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No Black, White, etc. 1 ☐Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: white 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2<sup>College (1-4or 5+)</sup> Elementary/Secondary (0-12) health care nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Esham Anne Humphreys 19a. Informant's Name/Relationship (Type. Print) Cheryl West/daughter 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) 7590 Esham Rd., Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/6/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Meno, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed

Be

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**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, it a Marical Examinating the putilised 34 once.

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/Medical ð Completed Be ဥ Certification:

Medical

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

29b. Signatury

4 Homicide

(Check or one)

State Registrar

24a. Was an autopsy performed 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)									
er: 4 🗆 Nursing H	ome	5 Residence	6 Other	(Specify)	tospic	0			
y at k?	28d.	Describe how inju	ury occurred	t					

1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

Oth

Name and address of person who completed cause of death (Item 23a) (Type, Print) Tatt

28a. Date of Injury (Month, Day, Year)

and manner stated.

32. Registrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** ()2i0 M Helen E. Randall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 1135 Madison St. Apt A2 Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov 24 Birthplace (State or Foreign
Country) **Funeral** Days Hours Year. 1 □ M 2 🗹 F Months Maryland 94 1914 216-12-5507 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou ampiorant: If item 27 is marked other than "natural", or items 23a or 28a-f shou print of items and the retified at once. 1 XYes 2 No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21403 1135 Madison St. Apt A2 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer State of Maryland 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eliza Whittington Claude Randall ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Boston(Niece) 929 Fall Ridge Way Gambrills, Md. 21054 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Marial 2 Cremation 3 Removal from State 5-7-09 Annapolis, Md. 4 Donation 5 Dother (Specify) Brewer Hill 21. Signature of Funeral Service Licensee Winame eRichers son Facility Sons Mortuary, P.A. Jarry M. Jesse nock 3 821 West St. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Jarr 821 West St. Annapolis, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 9 Hospital or Attending Physician: The law requires that the death certificate be executed your bouns after death.
9 Funeral Director. After this certificate has been signed by the attending physician and elely filled in by the funeral ciliector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) MAY 07

Name and address of perso



completed cause of death (Item 23a) (Type, Print)

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NNAPOCIS MOLIYO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) RUSSEII Month 2.5 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Salisbur WICOMICC norage If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Martha Pays Hours Min. (Month, Day, Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number, 7. Age (In yrs. last birthday) Year) Days 1**X**M 2□F 213-48-0227 62 Yrs 08/18/1946 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1X Yes 2 No Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 306 Truitt St. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) construction marketing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Stephen Russell Mary E. Hatton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Truitt St., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type, Print) Judith Russell/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/6/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Horroway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Huntinaton
Due to (or as a consequence of): DISERSE disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 2 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d Describe how injury occurred 28c. Injury at Work? 1 Natural

Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, ettanding physic for use es the b Division of Vital Records, P.O. detached director, : After this c 

**Physician** /Medical

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
and: If tem 27 is marked other then "netural; or items 23s or 28s-f show ury or other treamstite event, Its Macical Exertical must be notified at

permit. Page Depertment of Important: If eny Injury or once.

Physician

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Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to infine flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner by Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed 25. Was case referred to medical examiner? Medical Certification: To 27. Mannes of Death 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Babulal Das. 106 Milford ST # 504B, Salisbury, MD 21804

31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1,2009 Month May 12:55p<sup>M</sup> Andrew Leroy Savoy Jr 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George 17635 Eagle Harbor Rd Aquasco If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 3/1/1947 5. Social Security Number Days 1 □XM 2 □ F Washington DC 62 219-46-7821 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Xes 2 ☐ No Maryland Prince George Aquasco 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20608 17635 Eagle Harbor Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1968 1 D¥Yes 2 □ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 1974 Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Reliable Construction 12 Pipe Layer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes L. Wills Andrew Leroy Savoy Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17635 Eagle Harbor Rd, Aquasco, Maryland 20608 Fannie Mae Savoy/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 5/8/2009 MD Veterans Cem. 21. Signature of Fundral Service Licenses 22. Name and Address of Facility Adams Funeral Home PA, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Cancer

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

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Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 3 any Injury or other traumatic event, the Medical Examinar manonee.

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi

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filled in by the funeral director, page 2 should be detached for use as the burial-transit	al Certification: To Be Completed by Physician/Medical Examiner
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State Registrar 30. Name and address of person who completed

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31. Date filed (Month, Day,

	Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consequence of):					
Cause (Disease or injury that initiated events resulting in death) Last	C					
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ropic pregnancy ner (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions or	ontributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?		
			24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No		
25. Was case referred to medical		26. Place of Death	(Check only one)			
examiner? 1 ☐ Yes 2 A No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hom	e 5 <b>XX</b> esidence	6 ☐ Other (Specify)		
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury		28c. Injury at Work? 28d. Describe how injury occurred			
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	factory, office 2	8f. Location (Street ar City or Town, State	et and Number or Rural Route Number, State)		
	ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investi and manner stated.					
20h Signature and title of certifier		29c License number	29d Da	te signed (Month. Day, Year)		

20770

cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Lena R. Speelman 03 35 65 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICONICO YININSULD BEGIONAL MODICAL 4 Hrs 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🕱 F 578-05-8019 90 05/04/1919 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any follury or other traumatic event, the Medical Everning must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Wicomico Salisbury Director Maryland 1 Xes 2 No 10f. Zip Code 21804 10g. Citizen of What Country? 1103 S. Schumaker Dr., Apt. 306 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo white Specify: Completed by 3 □Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) real estate broker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Lafayette Massey Mary Agee ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 North St., N.E., Leesburg, VA 20176 19a. Informant's Name/Relationship (Type. Print) Mary Shaver/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 5/6/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Holloway Fuental Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cerebrovasular acudent 1 hr disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ASCUC 5 years Sequentially list conditions, to ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical nse IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. s been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 To the Hospital or Attending Physician: The 2 🗆 No 1 □ Yes Division of Vital 1 ∐ Yes 2 ₽No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Do 57359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST, SALISBURY 1415-5-DIVISION MD21804 usha Naturan 31. Date filed (Month, Day, Year) MAY () 8 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 6644 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 5:00 pM 2009 04Melva S. Tofsky May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Funeral Days Hours Months 1 ☐ M 2 🗷 F New York April 3, 1922 Director 87 156-01-9566 Usual Residence of Decedent the Maryland 10d Inside City Limits 10c. City, Town or Location 10a State 10b County 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanthar must be notified at 1 X Yes 2 □ No Director N. Bethesda Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20852 U.S.A 5800 Nicholson Lane, #807 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after of Hygiene. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify. Specify: Caucasian 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evones. Nettie Brettschneider ပ Frederick Sherman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5800 Nicholson Lane, #807, N. Bethesda, Maryland 20852 David Michael Tofsky - Son 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State King David Memorial Gardens 05/07/2009 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMON Sequentially list conditions, if any, leading to initial acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a nonsecuence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b DEMENTIE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 1 ☐Yes 2 ☑No Division of Vital After this certification, I 25. Was case referred to medical 26. Place of Death (Check onl one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending I hours a 'er dea'h. uneral Director Aft ely filled n by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DOD61096 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOLLAPALLI ROCKVILLE, 6121 MONTROSE ROAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 80 YAM Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 7:35 p Doris A. Tansley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Renaissance Gardens at Riderwood Village Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days Hours 1 □ M 203 F Washington, DC 579-44-1436 March 18, 1921 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State show ust be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Silver Spring 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 20904 3160 Gracefield Road, #3326 23a death \ Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status traumatic event. The Medical Examiner n Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo White Specify: Specify: 2 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Lionel Tansley Annie Catherine Connor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; if item 27 is any injury or other traionce. Margaret Mary Wolfe/Power of Attorney 7402 Galanin Drive, Annandale, VA 22003 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 12, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery, DC 4 ☐ Donation 5 ☐ Other (Specify) 2009 Washington, DC 21. Signa re if Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sanse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execute Hypertension and Due to (or as a consequence of): the burial-Box 68760. physician attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Division of Vital Records, P.O. ed by the s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Dementia, Kidney Disease, Chronic Renal Failure, Osteoporosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🛣 Nursing Home 5 🗌 Residence 6 🗋 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hou

To the Fune

completely fi (Check only and manner stated 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 2. Registrar's Signature

A

29c. License number

Gracefield Rd Silver String MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 8, 2009 10:30p.M Doris Mae Turner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Solomons Nursing Center Solomons Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Maryland 214-28-3856 80 01/01/1929 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Peolical Expedient munities to difficultations. 1 ☐ Yes 2 👿 No Director St. Leonard MD Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with Hygiene. U.S.A. Harbor Blvd. 20685 1321 Flag Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item Many Injury or other event, Item Many Injury or oth Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Vernon Whittington Ethel Mae Walton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kimberly K. Lopynski, daughter 3375 Broomes Island Rd., Port Republic, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Harmony Cemetery 05/12/2009 Owings, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the di eas shock, or heart failure. Immediate Cause (Final, ·Totavo **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cerebrougscular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) physician the burial P.O. Box 68760, Completed by Physician/Medical ed by the attending petached for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 I Linknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗗 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2. JRW

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

Name and address of person who completed cause of

MAY

32. Registraris Sig

2009

License number

TRINCE FredERICK, 1

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 Month **Physician** 07, May 8:15 a<sup>M</sup> Robert Thompson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Bay Ridge Nursing Home 8. Date of Birth (Month, Day, Yes June 11, Birthplace (State or Foreign Country) 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) <sup>Year)</sup>1924 **Funeral** Days Hours 84 Washington 578-20-0032 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes X No Director MD Anne Arundel Lothian 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20711 202 B Court Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: \$ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Maintenance Worker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be Unknown Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28020 6202 Ward Gap Rd. Casar, NC Arlene Lail (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Clinton, Maryland Resurrection 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral 2 ce Licensee MO1464 8125 Southern Maryland Blvd. Owings, MD 20736 John F. Holmes eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 🗆 No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After Injury (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

MOL

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

Dr. Ajit Kurup, M.D. 1835 University Blvd. Hyattsville, MD 20785

31. Date filed (Month, Day, Year)

32. Registrar Signature

10063661

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 For State Registramend 24-27,30 per Dr. g891 Sezuiforte of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PRINCEGEORGE If Under 1 Year Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number (In yrs. last birthday **Funeral** Hours Year) 3<sup>Min</sup> Months Days Maryland infant 1 ▼ M 2 □ F Jan 8, 2009 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23a or 20-4 any injury or other traumatic event, the Market and India process. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2√ No Director MD Prince George's Fort Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20744 6813 Middlefield Terrace USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 XI If Yes, Give Year or Dates: 1 M Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify ò Specify. 3 Widowed 4 Divorced black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Laquae Tyndle ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Southern Maryland Hospital 7503 Surratts Road Clinton, MD 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 MOther (Specify) in State 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signuture of Euneral Serv Baltimore, MD 21201 Approximate Interval Between Inset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do flot enter the mode of dying, such as cardiac or respiratory arrest, Cota Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): causinany flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 ANO 2□No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the huneral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

**Physician** /Medical

Examiner

Director

2 Accident 6 ☐ Could not be 3 Suicide determined 4 Homicide

and manner stated 29b. Signature and little of certifie

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

0034302 30. Name and address of person who completed cause of death (Hem 230) Type Print) Dr. Josephine Vergara, SMHC 7508 Surratts Rd. Clinton, MD 20735

State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

32. Registrar's Signature

		State of M  State of M  Registrar	aryland / Depa <i>Ce</i>	artment of Hortificate of D			ene g. No. 2009	16649
		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physicia		Harris Charles Wagam	an, Jr.			May 7,	2009 Year	9:30A. <sup>M</sup>
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death		4c. County of Deat	
		8649 St. Andrews Drive			ake Beac		Calvert	
Funeral Director		5. Social Security Number 6. Sex 7. Ac 1 № 1 № 1 1 № 1 1 № 1 № 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1	ge (In yrs. last birthday) 68 <sup>Yrs.</sup>	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 03/16/1	Year) 9. Birt 941 Pen	hplace (State or Foreign untry) nsylvania
put		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ecation				10d. Inside City Limits
//aryla	ō	MD Calvert		eake Beach				1 □ Yes 2 📉 No
the N	Director	10e. Street and Number	Chesape	10f. Zip Code		10	g. Citizen of What Co	untry?
3a ol		8649 St. Andrews Drive		207	32		U.S.A.	
ems (	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Midden Eventhar must be notified at	by FL	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give A 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	No	1 □Yes 2 No	Specify:	, ,		white
2 hou latura		15. Decedent's Education	16a. Dece	dent's Usual Occupa	tion	ing 1	6b. Kind of Business/	Industry
thin 7 ne. nan "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4ors)	life.	DO NOT use retired)	iring most of work	ing		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiant out be notified at once.	To Be	17. Father's Name (First, Middle, Last) Harris Charles Wagama	n. Sr.		18. Mother's Name Paulin			ers
shoul and M s marl umati	Ĕ	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a			City or Town, State, 2	-
and 2 salth a		Judith E. Wagaman, wife	8649	St. Andre	ws Dr.,	Chesapea	ke Beach,	MD 20732
es 1 a of He of He of the or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place	)	Date 2	20c. Location - City or	Town, State
Pag tment tant: I		4☐Donation 5 ☐Other (Specify)	So. Memo			2/2009	Dunkirk, N	1D
permit Depar Impor any in		21. Signature Funeral Service Licensee		2. Name and Address	ı\a	usch Fun ane, Owi	eral Home, ngs, MD 2	P.A. 0736
		23a. Part 1. Enter the disease, or complications that cause shock, or hear failure. List only one cause on each li	ine.			or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician / /Medical	ì	Immediate Cause (Final disease or condition resulting in death)	tatic nonsmal	I cert lung	cancer			8 months
Examiner		Due to (or as	a consequence of):	- 1				
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cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c						
oe execian a	EX	resulting in death) Last Due to (or as	a consequence of):					
physicate I	dical	d						
leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant					23d. Date of de	livery
death e atte d for u	iciar	in the past 12 months?		☐ Ectopic pregnancy ☐ Other <i>(specify)</i>			Month	Day Year
at the de by the a tached	hys	9 ☐ Unknown						
ires that signed I I be det	Š	Part II. Other significant conditions contributing to death t	out not resulting in the u	inderlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
w requires been si	eted							
ie law has b je 2 s	Completed					24a. Was ar autops	v I prior to	utopsy findings available completion of cause of
n: Th ificate or, pag		25. Was case referred to medical			aa Di (D	perform		s 2□No
Physician: The law this certificate has al director, page 2 a	o Be	examiner?	ent 2 ER/Outpatie	Otho	26. Place of Deat		nce 6 ⊡Other (Spe	acifu)
g Phy er this eral c	n: To	27. Manner of Death 28a. Date of Inj	ury 28b. Time o			28d. Describe ho		city
endin ath. or: Af he fur	atio	2 Accident investigation	ay, reary		es 2 □No			
or Atter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of In building, e	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 ⊂ ertifying Physician: To the best (Check only 2 Medical Examiner: On the basis	of examination and/or in	th occurred at the tim	ne, date and place pinion, death occu	, and due to the carred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
thin 2.	Medical	one) and manner si		29c. License			9d. Date signed (Mon	
7. ¥ 5. 8		utter (			56024		H47 20	
\ a		30. Name and address of person who completed cause of		Print)	and the state of t	العادة	0 20678	
Kn g			rage Signature	sale 110 (	rive tied	eack Pl	y 60611	
Sta Registr		31. Date filed (Month, Day; Year)  32. Regist  NAY 11 2000	Signature	1				

DHMH 17 Rev 1/2001

ORIGINAL

	•	For State Registrar	State of Marylan		rtment of tificate of		Re	g. No.	119	16650
Physici /Medi		1. Decedent's Name (First, Middle, Last)  Jane E. W	aller					2009	Year	3: Time of Death 10:55 AM
Examir	_	4a. Facility Name (If not institution, give s HCR Manor Care			Chevy (				ty of Death	
Funeral Director		377 02 1201	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Feb 9,	<sup>Year)</sup> 1920	Cou	place (State or Foreign ntry) sinia
Maryland f show led at	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgomer		ty, Town or Lo Che	evy Chase	9				10d. Inside City Limits 1 ☐ Yes 2 📉 🕷 o
with the I 3a or 28a- st be notifi	al Director	10e. Street and Number 8700 Jones Mill			10f. Zip Code 208	315		og. Citizen o United		
be filed within 72 hours after death with the Maryland that Hyglene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ ☒ ivorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ to If Yes, Give Year or Dates:		Vas Decedent of If Yes, specify Cu 1 ☐ Yes 2\forall \forall \forall \forall \forall Y	Hispanic Origin? (Sp ban, Mexican, Puerlo Specify:	pecify Yes or No- o Rican, etc.)		ace - Ameri lack, White, cify: B1	
nd 2 should be filed within 72 hours af lith and Mental Hyglene. 27 Is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Edu (Specify only highest grade Elementary(Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use retii 1estic	e during most of wor		16b. Kind of	Business/Ir ivate	-
should be filed very marked other umarked other umaric event, the	To Be Co	17. Father's Name (First, Middle, Last) Anderson Waller					ne (First, Middle, labeth Bla		ame)	
		19a. Informant's Name/Relationship (Ty	pe. Print) l (Daughter)	19b. Mailir 118	ng Address (Stree N. Harr	et and Number or Ru ison Road	ral Route Number , Sterlir	ng, Va	2016	+
permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tr		20a. Method of Disposition  1 X Vsurial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crei shingto		ial Park		_	ton, \	Virginia
permit. Departi		21. Strinature Funeral Service Line	Upon 90	$2J \mid I$	lexandr	ia Ferry I	Road, Cli	inton.	, Inc	20735
Physician		23a. Part 1. Eyer the disease or compl shock, of heart fajure. List only of Immediate sause (Fixel disease or condition resulting in death)	Aspiratio	n Pneur		ying, such as cardiad	or respiratory ari	est,		Approximate Interval Between Onset and Death
/Medical Examiner	er		Due to (or as a conse  Dementia  Due to (or as a conse							
ficate be executed physician and s the burial-transit	I Examine	Sequentially list conditions, and the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1.0							
artificate bing physic	Medical	IF FEMALE:	Diabetes		1S					
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf preging 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[	⊒Ectopic pregna ⊒ Other (specify)			230.	Date of deli Month	Day Year
w requires that the d been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	anderlying cause	given in Part I.		obacco use d ∕es 2□N		the cause of death?
siclan: The law requires t certificate has been signe rector, page 2 should be c	Completed						24a. Was autop perfo 1 Yes	an 24 osy rmjed? 2∐No	4b. Were au prior to death? 1 ∐ Yes	topsy findings availab completion of cause of 2 ☐ No
Physiclan: this certifier	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2[	☐ ER/Outpatie	nt 3□ DOA (		ath <i>(Check only o</i> Home 5 ☐ Resid		Other (Spe	cify)
ing Affe	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	njury at Vork? □ Yes 2 □ No	Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred						
To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec	ciry)			City or Tov	vn, State)		ural Route Number,
e Hospi 24 hour e Funer	Medical	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medical Exam	rsician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at the nvestigation, in n	e time, date and plac ny opinion, death occ	e, and due to the curred at the time,	date and pla	ace, and due	e to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	Volva	M. 8		ense number 0274			gned (Mont 4, 20	h, Day, Year) 09
BH		30. Name and address of person who con Kirti Vohra, M.D	ompleted cause of death (It	em 23a) (Type Blvd,	Print) Bethesd	a, MD 208	17			
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		6.41					

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 6, 2009 Frederick Warholoski 10:30 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Southern Maryland Hospital $\begin{array}{c|cccc} \hline \textbf{Clintoli} \\ \hline \textbf{If Under 1 Year} & \hline \textbf{If Under 24 Hrs.} & \textbf{8. Date of Birth} \\ \hline \textbf{Months} & Days & Hours & Min. \\ \hline \textbf{Monthy} & Days & Dec & 11, \\ \hline \end{array}$ Clinton. Prince George's 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1945 63 Nebraska 507 56 6566 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√1No Maryland Prince George's Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5605 S. Marwood Blvd #417 20772 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 TV Yes 2 □ No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married 1 □ Yes 2X□XNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Binder Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Warholoski Julia Wruble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lou Ann Hoelscher (SISTER) 5901 Abigail Drive, Lincoln, Nebraska, 68516 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee Crematory May 7, 2009 4 □ Donation 5 □ Other (Specify) Clinton, Maryland 21. Signal re of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown MYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy performed? res 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

The law requires that the death certificate be executed and P.O. Box 68760. physician the as attending I asn signed by the a Division of Vital Records, has page 2 certificate Hospital or Attending Physician;

Examiner Physician/Medical þ Completed Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

ir than "natural", or items 23a or 28a-f sho

72 hours after

permit. Pages 1 and 2 should be filed within 72 hours aftu Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or is any injury or other traumatic event

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

₽

Completed

Be

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within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire

1 ☐ Yes 27. Manner of Death

1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 Suicide 4 Homicide

Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

address of person who cor

31. Date filed (Month

29a, Certifier

29b. Signature and title of certific

d cause of death (Item 23a) Type, P

and manner stated.

SURRAMS ROAD #302

29d. Date signed (Month, Day, Year)

State Registrar

Medical

8 2009

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2009 ∩u /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ouns Hopkins 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Yrs. Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? Montcalm death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) nfant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan Pages 1 and 2 should be I 19b. Mailing Address (Street and Number or Rural Rodte Number, City or Town, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Johns Hopkins Bayview may 5 4 Donation 5 Other (Specify) WOST, tul distisal 21. Signature of Funeral Service Licenses 22. ame and Addr as of Facility 4940 BASTERNAVENE BALTIMORE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prema **Physician** MIN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for sels consequence of burial-trar and Due to (or as a consequence of) Box 68760. physician Physician/Medical the use as attending IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Dav Year 5 ☐ Other (specify) P.0. been signed by the s 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an has autopsy perform Division or Vital 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 📉 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registra

31. Date filed (Month, Day, Year)

4940 Eastern Ave

DHMH 17 Rev 1/2001

State

Registrar

11811 Prince Philip Dr.Olney, Md. 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Excur

Ata Motamedi MD

08

2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #21 Per FH G891 5/27/09 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 11:10 A M **Physician** May 21, Marian V. Armiger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/14/1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛭 F Marvland 81 Director 217-24-7967 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examine must be notified any injury or other traumatic event, its Medical Examine. 1 ☐ Yes 2XXNo Director MD Baltimore Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21236 Funeral 32 Stewarton Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 12 should be filed within 72 hours after ر h and Mental Hygiene. 'is marked other than "natures!" مه تقدیم 1 □Yes 2X If Yes, Give Year or Dates: 2**X X**No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify: White 夕 3XXWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales person 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Valentine Claude Richard Pyne ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8600 Jessica Lane Perry Hall, MD 21128 Mrs. Claudia Pawlak / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specific Intombrent 5/26/2009 Moreland Memorial Park Baltimore, MD 22. Name and Address of Facility 5305 Harford Rd. 21. Signature of Funeral Service Licensee M01466 Baltimore, MD 21214 Leonard J. Ruck, Inc. per DVR Blair Alexandria J. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Playman Vascular distase Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 □Yes ospital or Attending Physician: 'hours after death. Ineral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Scher (Specify) WOSPUL 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral E Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST PONISON 6201 CHARLES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26 2009 Registrar

211

		1 - State Registrar		rtificate of Death	-	Reg. No.2009	
Phys		Decedent's Name (First, Middle, Last)  Lui	er	2. Date of Dea Month	ath Day ay 19, 2009	3. Time of Death 8:00a M	
/Me Exan	dical niner	4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location of	Death	4c. County of Deat	
46	20	707 Bartlett A		If Under 1 Year   If Under 2	Baltimore		/A
Funer Directo		5. Social Security Number  212-46-1003  Usual Residence of Decedent	7. Age (In yrs. last birthday) 65 Yrs.	Months Days Hours	Min. 8. Date of Birt (Month, Da) Apr 14,	v. Year) Co	hplace (State or Foreign untry) <b>Maryland</b>
Maryland t-f show fied at	tor	10a. State 10b. County	10c. City, Town or Lo	Baltimore			10d. Inside City Limits 1 Yes 2 No
th with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 707 Bartlett Avenue		10f. Zip Code 21218		10g. Citizen of What Co U.S.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	þ	3 ☐ Widowed 4 ☑ Divorced Year or Da	2 □ No /e .	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☑ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)		
Baltimore, Maryland 21215-0036  sermit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Higiene. Important: If Item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examl	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1	16a. Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired)  City Err		ne during most of working red)		Industry City Parks
be filed v tal Hygie d other i	Be Co	17. Father's Name (First, Middle, Last)			s Name <i>(First, Middle,</i>	,	
arylar should be and Menta s marked umatic ev	To E	Luke E. Alexander			Sara	h Alexander	
Te, Mar 1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship (Type. Print)  Louise Comegys	70	ng Address (Street and Number 17 Bartlett Avenue Ball			(ip Code)
imore Pages 1 ment of He ant: If Iten		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donardon 6 ☐ Other (Specify)	State	sition (Name of matory or other place) us Memorial Park	05/28/09	20c. Location - City or Baltimore,	
Balti permit. Departr Importa any Inju	ouce	21. Signature Funeral Service Licens	2/8-1	2. Name and Address of Facility Estep Brothers F 1300 Futaw Place	uneral Service, e Baltimore, Mo	P. A. 121217	
by Counting the principle of the purishment of t	al	Sequentially list conditions, If any team of the manufacture cause. Enter Underlying Cause (Disease or injury that initiated events		Cey Carcine			Interval Between Onset and Death Onc Jean
BOX ath cer attendir or use	by Physician/Mec	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of del Month	livery Day Year
rds, P.O. I quires that the de n signed by the a	d by Ph	Part II. Other significant conditions contributing to de	ath but not resulting in the ur	nderlying cause given in Part I,	23e. Did to	obacco use contribute to	o the cause of death?
or VItal KECOrds, hystelan: The law requires this certificate has been signe I director, page 2 should be or	Completed				24a. Was autop perfo 1∐ Yes	prior to death?	utopsy findings available completion of cause of 2 \square No
Or VITa Physician: rthis certific ral director,	a	25. Was case referred to medical examiner?			of Death (Check only o	ne)	
To the Hospital or Attending Physician: 1 to the Hospital or Attending Physician: 1 within 24 hours after death.  To the Funeral Director: After this certificat completely filled in by the funeral director, p.	Certification: To	27. Manney of Death  1 Natural 2 Accident investigation 3 Suicide 6 Could not be 28e. Place	th, Day Year) Injury of injury - At home, farm, str.	f 28c. Injury at Work?  M 1 Yes 2 N	28d. Describe I	dence 6 Other (Spe how injury occurred Street and Number or Ru	
To the Hospital or within 24 hours after Funeral Director Completely filled in h		4 Homicide buildi  29a. Certifier (Check only 2 Medical Examiner: On the base)	ng, etc. (Specify)  best of my knowledge, death	h occurred at the time, date and	City or Tov	cause(s) and manner as	s stated.
To the He within 24 To the Fi complete	Medical	one) and man	ner stated.				
, 5 with 5 no	2	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mont	
		一人人人人	٠,	20006.	346	05/22	-12009
· · · · · ·		30. Name and address of person who completed caus  SHAN7HI MARU  31. Date filed (Month, Day, Year) 32. R	9 of death (Item 23a) (Type, 1650 OKLCA)	DODGE.  Print)  NS STREET  Sparked	/ROOM G	92 BALT	YMORE - MA
Regis	State strar	31. Date filed (Month, Day, Year)	Museum B.	parker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Dav Month MAY 2009 2:28 PM DESHAWN AIKENS 6 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMONE BAYVIEW MEDICAL CENTER HOPKINS If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify 3 ☐ Widowed 4 ☑ Divorced 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) rivate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) (mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Crematory 21. Sign ure of Funeral Service License 22. Name and Address of Facility Jose 23a. Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final disease or condition resulting in death) RESPIRATORY ALLEST 5 DA45 Due to (or as a consequence of): 5 Days ASPILATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to for as a consequence of Due to (or as a consequence of) outcome of pregnancy ve birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy gnant at time of death 5 ☐ Other (specify) known 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

show

Director

Funeral

2

Completed

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? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exarcinar must be rectified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Ite Meany once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical δ cate has been si Completed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, o 1
Part II. Other significant condition	ns contributing to

5 ☐ Pending investigation

6 ☐ Could not be

(Cl	heck only one)	
ne	5 Residence	6 ☐Other (Specify)
284	Describe how init	iry occurred

BALTIMORE.

2 □No 1 ☐ Yes

21224

3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
9a. Certifier	1 Certifying Physic	cian: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.

29a. Certifier	1 Certifying Physician: To the best of my knowledge, dea		
(Check only	2 Medical Examiner: On the basis of examination and/or i	nvestigation, in my opinion, death occurred at the tin	ne, date and place, and due to the cause(s)
one)	and manner stated.		
29b. Signature and	I title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

		2024	pootie.	
^	Name and address	of person who	ompleted cause of death (Item 23a) (Type P	rii

ZES 000

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death Other: 4 \sum Nursing Hor

> 16 2009

SUHAIL MITHANI 4940 EASTERN AVENUE M.D.

31. Date filed (Month, Day,

25. Was case referred to medical examiner?

2 X No

1 Yes

27. Manner of Death 1 Natural

2 Accident

32. Registrar's Signature

1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28a. Date of Injury (Month, Day, Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Dav 6:20 PM 21 2009 Anderson May Donald 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Glen Burnie Anne Arundel North Arundel Rehab. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) Year) Sept. 24,<u>1914</u> Maryland 94 214-03-2950 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a, State 1 Tyes 2 Tillo Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 U.S.A. 1764 Bayside Beach Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Exxon Purchasing Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Bosley Anderson Stephen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1764 Bayside Beach Road Pasdena, Maryland 21122 Donna K. Anderson (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 05/26/09 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arrhy thuis Immediate Cause (Final ordine disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify)

Physician /Medical Examiner

certificate be executed

Box 68760,

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Division of Vital Records,

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Expuniter must be refined any once.

Baltimore, Maryland 21215-0036

and burial-trar physician a the burial attending p use as the þ signed t been has page 2 certificate ! To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director,

Examiner Physician/Medical 2 Completed Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

29a. Certifier

(Check only

Pregnant at time of death 9 I Inknown

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown

24a. Was an autopsy performe 1 ☐Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 No

26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D-40521 29d. Date signed (Month, Day, Year) 22,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 HOSPITAL DRIVE SUITE 805 GLED BURNIE, NO 21061 OCHANEJ

State Registrar

filled in by the

Medical

10 V

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** 18, 11:35 PM May Bussard Frances Ione /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Sunrise Nursing Home 8. Date of Birth (Month, Day, Jun. 1, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Year) 1920 Months Days Hours Min. 1 □ M 2 🖫 F Jun. West Virginia 88 236-28-2477 Director Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mertal Hygiene. The marked other than "natural", or items 23a or 28a-f show wither traumatic event, II: Mexical Eventing must be rediffed at 10a. State 10c. City, Town or Location 1 X Yes 2 ☐ No Director Arlington VA 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 22204 1100 South Forest Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 ∑XNo If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ⋧ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) US Treasury Elementary/Secondary (0-12) College (1-4or 5+) Department Budget Analyst 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Annie Sarah Dever Clyde Given Bussard, Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr 3413 Briars Road, Brookeville, MD Tamma Hammond/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mountain View
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-22-2009 4 ☐ Donation 5 ☐ Other (Specify) Marlinton, WV 22. Name and Address of Facility VanReenen Funeral Home 21. Signature of Funeral Service Licensee 207 9th Street, Marlinton, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 8 Months **Physician** Metastatic Brain Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Failure to Thrive Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia autopsy performed? Yes 2 No Hospital or Attending Physician: The certificate 1 Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Be ( 25. Was case referred to medical examiner? director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. nours after death neral Director: / filled in by the fi 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D53362 May 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan, MD 9801 Georgia Ave., Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 26 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2ďÖ9 Eugene M. Barnes May 11:30 P™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 542 46th Street Baltimore Dundalk If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 24, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 64 Director Maryland 215-40-7727 Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Dundalk Maryland Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21224 542 46th Street USA 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2X Married 1 □Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Harvey Barnes Mildred Morton Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 of Health a item 27 is 542 46th Street Baltimore, Maryland 21224 Deneen Y. Brooks, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/22/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Homas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final **Physician** -0 ancer ION reass disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the marrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physician and as the burial-tran Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical the attending IF FFMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performe 1 □Yes 2 □No 1 ☐Yes 2 ☐No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) After this of funeral dire မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural (Month, Day, Year) Injury 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Ar completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical

Registrar

Baltimore, Maryland 21215-0036

O. Box 68760,

σ.

Division of Vital Records.

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Desai

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore MD 21231

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 656U Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3:57PM **Physician** Beyerly 5 ack /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Daltimore Med If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Şex 1XI'M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days 180-36-1984 Q Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Examiner must be notified at once. 1 ☐ Yes 2 No Funeral Director MD ewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21040 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Years Jursing Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Dlackmon James ပ္ amona 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) drienne 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Home P.A 21. Signature of Funeral Service Licensee 638 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician perRale /Medical Due to sa a consequence of): **Examiner** arlur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consecuence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To . Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ר 24 hours af וויסל 24 hours af וויסל 124 hours af iletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Hosp within 24 hor To the Fune (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2 0 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ana /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner BALTIMO 270 CJOE AL IMOR 20 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Fore Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex ([n yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 🖫 🗲 2(5-76-291) Usual Residence of Decedent 1962 Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 √es 2 No MD Directo timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or Pages 1 and 2 should be filed within 72 hours after death with 21216 Funeral Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race items; Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 9 þ American 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) erk Grade NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be romas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 26 19a. Informant's Name/Relationship (Type. Print) Baltimore MO Department of Health a Important: If item 27 is any Injury or other trau once. Keland + Curry 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Boutmore 05-29-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility Wylie Funeral Home P. A. 21. Signature of Functal Service Licenses Street Baltimore MO 21217 Gilmor Approximate Interval Between Onset and Death 23a Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Die to (or all a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 ☐ Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 N nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 2 **X** No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28d. Describe how injury occurred 27 Manner of Death Date o'Nnjury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation n 24 hours after death.

e Funeral Director: Aft 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Che and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sign Name and add cause of death (Item 23a) (Type, Print) MA 2000 RD

State

Registrar

31. Date filed (Month, Day, Year)

26

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 22 2009 10:46 May BETHEA ROSEMARY Ρ. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 3407 ELMORA AVENUE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 □ M 2XX MARYLAND NOV. 16 1945 63 Director 215-46-7330 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evandrant must be notified at 1 X Yes 2 □ No Director MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 3407 ELMORA AVENUE 21213 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 □Yes XXNo Baltimore, Maryland 21215-0036 Specify Specify: BLACK δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumeth. Elementary/Secondary (0-12) College (1-4or 5+) SINAI HOSPITAL WARD CLERK ADMIN. 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DORIS M CHAMPLIN FRED WOODS ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4202 Sihler Oaks Trail, Owings Mills, Md., 21117 Robert Trafton/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 06-01-09 OWINGS MILLS, MARYLAND 4 Donation 5 Other (Specify) GARRISON FOREST 21. Signature of Fun ra WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE RIRIUM 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Immedia H **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner lascular disease phor Sequentially list conditions, if any, leading L. In the Jate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) The law requires that the death certificate be executed Examin burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? has this certificate the Hospital or Attending Physician: To the Hospital or Attending PhysIclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1□Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

DHMH 17 Rev 1/200

Registrar

Rodne

31. Date filed (Month, Day,

leve B. parker

3120

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

36

Avenue.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Bauer Physician 20 2009 usan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore Medical Hopkins Bayview N/A 8. Date of Birth (Month, Day, Year)
Feb. 28,1948 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2√2 F Maryland Director 218-44-3609 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location Show 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Modeal Examination is just be notified at 1 ☐ Yes 2X No Director Dunda1k Maryland Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21222 United States 1940 Hazelmere Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2★1 No If Yes, Give Year or Dates: Wever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√TXNo Specify Specify. ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event," In Man Elementary/Secondary (0-12) College (1-4or 5+) Clerical Office Manager 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rita Ptak Norman Bauer ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk, Maryland 21222 7831 Lockwood Road Mr. Walter W. Schuebel (Son) Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 5/23/2009 Middle River, MD ♣☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Sign are of Funeral Servic Licen ee 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Multiple Immediate Cause (Final Physician 72 disease or condition resulting in death) /Medical Due to (or as | consequence of): Examiner Sequentially list conditions Examiner as a conse wence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Ulcer attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 I Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 XNO 1 Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) timore Gleorge 1

DHMH 17 Rev 1/2001

State Registra

32. Registrar's Signature

Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 22, 2009 **Physician** 6:05Рм Samuel S. Barnaba /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 7, 1926 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XXM 2□ F Marvil and 83 218-18-6488 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b County d other than "natural", or items 23a or 28a-f show event, it. Wodical Examinar must be notified at 1 ∐Yes 2**XX**No Funeral Director Parkville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21234 8620 Ouentin Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🛣 No Specify: Specify: White Completed by **¾**Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ". wental Hygiene."
127 is marked other than "retraumatic event." Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental Michael Barnaba Josephine Lucchesi ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health 1405 Buckthorn Drive Jarrettsville, MD 21084 Mrs. Elizabeth Doged / Daughter Department of Health Important: If item 27 any injury or other tonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/28/2009 Baltimore, MD Moreland Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Rd. 21. Signature of Funeral Sarvice License 22. Name and Address of Facility Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC COLON CANCEL 2002 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner tie to lar as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed and burial-trar Due to (or as a consequence of): Box 68760, physician the burial requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No Ö 9 I Inknown ۵. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 HRONIC KLONEN USEASE 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t performed? certificate After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 064395 MAY 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHAPLES ST, SUITE 209 BATTMONE, MJ 21204 DOBERMAN, MD State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #30 per DVR 8891 5/26/09 TT
State of Maryland / Department of Health and Mental Hygiene?

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау **Physician** Month Year M Gloria S. Boynton 9:09a May 19, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A 124 West Franklin Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 □ M 2 □ F Director 213-30-6705 Jun 27, 1927 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 □ No Director Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 'natural", or items 23a 124 West Franklin Street 21201 U.S.A. 2 should be filled within 72 hours after death v n and Mental Hygiene. Is marked other than "natural", or items 23 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐No Specify. 3 □ Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event ODE. Moriah Grandy Richard Grandy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Boynton 7712 Locust Lane Fort Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 5 ☐ Other (Specify) 05/23/09 Baltimore, Maryland 4 Donation Arbutus Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1306 Eutaw Place Beltimore, Md 21217 ode of dying, such as cardiac or respiratory arrest, se, or complications that caused the death. List only one cause on each line. 23a. Part 1. Enter the dist enter the mode Approximate Interval Between shock, or heart failur Onset and Death Immediate Cause (Findisease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and certificate be exec Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE: for use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \subseteq Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Mannier of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🖬 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and activess of pelson who completed cause of death (Item 23a) (Type, Print) Keiffer J. Mitchell, MD 1230 Druid Hill Ave. Baltimore, MD 21217 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

State of Maryland / Department of Health and Mental Hygiene 🕦 🗎 🧐 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Year **Physician** 6:00 AM 5/21/2009 Thelma Barnes /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mt. Airy

If Under 1 Year If Under 24 Hrs. Months Days Hours Min.

8. Date of Birth (Month, Day, Year 3/9/1922 5306 Ridge Rd. Carrol1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Director 87 MD 212-22-4633 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Carroll Mt. Airv 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5306 Ridge Rd. 21771 USA Pages 1 and 2 should be filed within 72 hours after deathnent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ģ Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Secretary Van Sant Plumbing & Ht. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked o Vernon Willard Shipley Blanche May Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5926 Ridge Rd., Mt. Airy, MD 21771 Gerald B. McGiffin/Friend injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Seurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/26/2009 Mt. Airy, MD Prospect Cemetery 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Myosardial Immediate Cause (Final disease or condition resulting in death) trute **Physician** minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine affending physician and for use as the burial-fransit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Denression been sig 1□Yes 2☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1□ Yes 2□No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death uneral Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier

MKM Z vm W 29c. License number 29d. Date signed (Month, Day, Year) D 33681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAY ELDERSBURG MD MCEVOY 1380 PROGRESS

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 22, 2009 2:15 A<sup>M</sup> Georgia Burch Benson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Timonium Baltimore Lorien at Mays Chapel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 💢 F Yrs Dec. 12, 1931 Maryland Director 218-28-0868 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Timonium Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21093 USA 52 Gerard Ave. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: White Specify. þ 3 ☐ Widowed 4 🛣 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Advertising Commerical Artist 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Doris Harker ပ George Burch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 Bynum Ridge Road Forest Hill, MD 21050 Department of Health Important: If item 27 any injury or other tr Ellen Lutrey/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 28, 1 XBurial 2 ☐ Cremation 3 Removal from State Louden Park Cemetery 4 □ Donation 5 □ Other (Specify 2009 Baltimore, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
Flagle 10 W. Padonia Road Timonium, MD 21093 21. Signature of Inc. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death . Fant1. Enter the disease, of shock, or heart failure. List complication Immediate Cause (Final disease or condition resulting in death) plications **Physician** 1ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No ģ 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş Q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe death? 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No

P.O. Box 68760,

funeral director, After this

Certification: To

Division or Vital Records, ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti the completely filled in by within 24

State

5 ☐ Pending investigation

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifie

6 ☐ Could not be

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

St, PPEZO9, Balto

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Er Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d, Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 26 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 12:02 PM ward 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 13609 Brookline Road Baltimore Baldwin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Min Months Days Hours 213-24-959 Maryland 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 □Yes 2 □ No MD Baltimore Baldwin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21013 13609 Brookline Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 XYes 2 No
If Yes, Give
Year or Dates: Korea 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 🕱 No Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Whiting-Turner Elementary/Secondary (0-12) College (1-4or 5+) Executive V.P Contractors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Mercer William L. Burger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13609 Brookline Rd., Baldwin, <u>Ellen M. Burger / Wife</u> MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Hilltop Service Corp. 5/26/09 Towson, MD 4 □ Donation S ☐ Other (Specify) 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home 21204 Towson. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lly one cause on each line. Immediate Cause (Final Maligrant Months disease or condition resulting in death) Due to ( a consequence of): Sequentially list conditions Due to (or as a consequence of) it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 200.000.

/Medical

Director

Funeral

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he Funeral Director: Af

25. Was case referred to medical examiner?	

1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 2

9a. Certifier (Check only one)	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.						
9b. Signature and	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				

Bultimore, MD 21204

N. Charles St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUNSMORE 6701 ATHAN MI

31. Date filed (Month, Day, Year) 32. Registrar's Signature

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			For State Registrar	State of	Maryland / De	epartment of Certificate o			giene Reg. No. 20	09 16669
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	rted nsit	nju	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or	as a consequence of)	:				
,	ttending Physician: The law requires that the death certificate be executed beath.  Jeach.  After this certificate has been signed by the attending physician and toor. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequence of)					
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3	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical								anner as stated. and due to the cause(s)
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	61		30. Name and address of person who		of death (Item 23a) (Ty	/pe, Print)	14010	OF CUTTER	200 RAI-	-2, 2009 MME, MD 21204
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\gamma$ Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 200 Benkler Kh: 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Tox 1050 last birthday) 87 Security Number Months Days **Funeral** 1 □ M 2 X F Yrs. 217-45-8018 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exacting contact the matthes 10a. State 1 □ Yes 2 XXIO OWINGS MILLS BALTIMORE **Funeral Director** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21117 3410 ASSOCIATED WAY #203 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Specify:WHITE 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: <u>ک</u> 3 ₩Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) MEDICAL College (1-4or 5+) Elementary/Secondary (0-12) PEDIATRICIAN 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN 17. Father's Name (First, Middle, Last) SOPHIA Be THUREPH LAZAR ဂ 8003 GREENSPRING WAY UNIT CUMON FINGS MILES (MD 21117 19a. Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of OHEB SHALOM MEM. 20a. Method of Disposition REISTERSTOWN, MD 5/22/2009 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility o uneral/Service Lic nse 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 11. Enter the disease, or complications for caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Mal Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death Year Day 3 ☐ Ectopic pregnancy Month 23b. Was decedent pregnant in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 2 Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 🗆 Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Hospital: 1 Inpatient 2 **N**0 1∐ Yes Medical Certification: To 28d. Describe how injury occurred Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 5 Pending 1 Natural 1 ∏Yes 2 ∏No investigation 2 Naccident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I

3altimore, Maryland 21215-0036

State Registrar 4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yea Month **Physician** 11:15 4 Adam Harrison Curtis 5 2ĺ 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balto Future Care Charles

5. Social Security Number | 6. Sex | 7. Agr Village e (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year **Funeral** Days Min XXM 2□ F 78 Yrs. 215-28-5267 9 1931 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at MD N/A XX es 2 □ No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 715 E. 22nd Street Funeral 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? ty Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 XNo Specify. Black Specify <u>م</u> 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th grade Balto Gas & Elec College (1-4or 5+) Tankerman N/A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 21°, Month May 20**0**9 12:03P M Charles C. Columbus 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Annapolis 1200 Hilltop Drive If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, March 29 9. Birthplace (State or Foreign Country) DISTRICT 5. Social Security Number 7 Age (In vrs. last birthday) Year) 1**X** M 2□ F 86 578-16-3012 1923 Of Columbia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🗓 No Annapolis Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21409 **USA** 1200 Hilltop Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1∑Yes 2 No 1941 If Yes, Give Year or Dates: 1945 1 Never Married 2X Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles C. Columbus Sr. Catherine Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1200 Hilltop Drive Annapolis, Maryland 21409 Elizabeth Columbus, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 05/22/09 Baltimore, Maryland Cremation Society Of Maryland, Inc. 21. Signature of Funeral Service Licensee Thomas Gregor Thomas 299 Frederick Road Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pheumoma Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) □Yes 2□No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ole

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: if item 27 is marked other the any Injury or other traumatic event, the

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

**Funeral** 

**Director** 

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exemitment man be needling at

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and burial-trar attending physician for use as the buria the þ has certificate

the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner he Hospital or Attending P in 24 hours after death.
he Funeral Director: After t pletely filled in by the funera

9 Unknown

Physician/Medical \$ Completed Be Certification: To

Medical

within 2 To the I

State Registrar

	11.00					
				24a. Was an autopsy performed?	24b. Were autopsy findings availat prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
25. Was case referred to medical	1		26. Place of Death	(Check only one)		
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nurs			Home 5 ■ Residence 6 □ Other (Specify)		
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day, Year)	Injury   V	njuryat 2. /ork? □Yes 2□No	8d. Describe how injury	y occurred	
3 ☐ Suicide 6 ☐ Could not determine		e 2	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	Physician: To the best of my knowle aminer: On the basis of examination					

29b. Signature and title of certifier humhall mp

29c. License number

29d. Date signed (Month, Day, Year)

D23867 5-21-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), THOMAS WALSH MD 115 SalliH Drive Stevensville, MD 21666

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Clark 20, Loretta 2009 10:52PM May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) Aug. 21, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 🛣 F 213-10-3300 88 1920 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Madical Examinator resust by retified at 1 ☐Yes 2 NO Director MD Millersville Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 703 Pumphrey Farm Drive 21108 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ð 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimoe City Elementary/Secondary (0-12) College (1-4or 5+) School System Vision & Hearing Tester permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Hartley Sophia Ciemny ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara Van Horn/Daughter 703 Pumphrey Drive Millerville, MD. 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  $\frac{\text{May 26}}{2009}$ Meadowridge Mem. Park Elkridge, MD 22. Name and Address of Facility Singleton Funeral & Cremation Puneral Ser ce Licensee Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part 1 Enter the disease Immediate Cause (Final 4840 **Physician** men disease or condition resulting in death) /Medical a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 2 → NO 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? certificate 2 N 1 ☐ Yes 2/ No 1 ☐ Yes the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖺 🕽 1 Inpatient 2 DER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month) Day, Year) 29b. Signature and title of certifier 29c. License number ٥ 30. Name and address of person who completed cause of death (Item 23) (Type, Print) 110 31. Date filed (Month, Day, Registrar's Signat State Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, 6892, 678709, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death

2. Date of Death

		•	For State Registrar		State of Ma	arylanc	-	rtment of F tificate of I		nd Men		giene , Reg. No. '	2009	166	75
H	Dhuaiaic		1. Decedent's Nam	e (First, Middle, Last)							Date of Dea	ith Day	Ye ак	3. Time of Do	
		Physician Jerome Deville						h Ch Tayana I agation of Doobh			21	2009	9:30A	M	
	Examin	er	4a. Facility Name (If not institution, give street and number)  Northwest Seasons Hospice  Randallstown								4c. C	County of Death	imore		
_	Funeral	5, Social Security Number 6, Sex 7. Age (In yrs. last birthday)						If Under 1 Year	I I S L O If Under 24 Hours	4 Hrs.   8. [	Date of Birti	h ( Vear)	9. Birth	place (State or I	Foreign
	Director		577-90-8995 11xm 20 50 Yrs. 06-24-58								DC				
	w w	-	Usual Residence o 10a. State	f Decedent 10b, County		10c. City,	Town or Loc	cation						10d. Inside City	Limits
	Maryla f sho	Ö	MD	NA			timo							¶Yes 2	. □ No
	r 28a	Director	10e. Street and Nu					10f. Zip Code	·			10g. Citiz	en of What Cou	ntry?	
	th with		1805 F	orest Pai	ck Aveni	1e		2120					USA		
	tems	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)	1	<ol> <li>Race - Ameri Black, White,</li> </ol>		
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the legical Extraplace must be notified at	by F	1   Never Marr  Widowed	ried 2 Married 4 Divorced	1 □ Yes 2 🛣 If Yes, Give Year or Dates:	No	1	I□Yes 2√XNo	Specify:				Specify: B1a	c k	
5	2 hou latura	ted		15. Decedent's Educ cify only highest grade			16a. Deced	lent's Usual Occup	ation	of working		16b. Kin	d of Business/Ir	ndustry	
7	ithin 7 ne. nan "n	Completed	Elementary/Seco		College (1-4or	5+)		kind of work done		or working		NCI	Δ		
7	filed within Hygiene. other than "		Unk.	(First, Middle, Last)	unk.			Jánitor		's Name (Fil	rst. Middle.				
<u></u>	d be fi	) Be	17. Father's Name	(First, Middle, Last)	UNK.					eresa			ville		
ב ב	should and Men s marke umatic	ဥ	19a. Informant's N	lame/Relationship (Typ	pe. Print)	- 7	19b. Mailin	ng Address (Street						ip Code)	
, K	and 2 ealth a n 27 is		Rodney	Norris			· -	Ambass		Road	Wind				244
ב	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Dis	sposition	emoval from State	20b. Pla	ace of Dispo metery, cren	sition (Name of natory or other plac	ce)	Date		20c. Loc	cation - City or T	own, State	
allillo	t. Pag tment tant:		4 ☐ Donation	5 ☐ Other (Specify)		Mt.		n Cem.					sdowne		
מ	permit Depar Impor any ir		21. Signature of F	uneral Service License	e .			. Name and Addre							217
			23a. Part 1. Enter	the disease, or compli	cations that cause	d the death.		38 N. G er the mode of dyli					imore,	Approximate	
	hysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition									ath			
	/Medical		resulting in death)		Due to (or as	a consequ	ence of):								
	Examiner	L	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):												
	ted rsit	nine	if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury Cause, (Disease o												
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8	ertifice ing ph e as th	Med	IF FEMALE:						-				1		
Š	ath ce	Physician/M	23b. Was deceder in the past 12	nt pregnant	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant	2 🗌 Fetal	death 3	Ectopic pregnanc	су			2	3d. Date of deli Month	,	ear
5	the de	ysic	1 ☐ Yes 2 9 ☐ Unknow		9 ☐ Unknown	at time of de	aui 5L	Other (specify) _							
7.	s that ned b deta	by Ph	Part II. Other sign	ificant conditions cor	ntributing to death t	out not resu	Iting in the u	nderlying cause giv	en in Part I.		23e. Did t	obacco u	se contribute to	the cause of de	ath?
ecorus,	equire: en sig ould br										1 🗆 `	Yes 2	No 3∏ Pro	obably 4 💢 Ui	nknown
200	law re as be 2 sho	Completed									24a. Was	osy	prior to c	topsy findings a completion of ca	vailable use of
ב =	: The cate h	So									perfo 1 □ Yes	rmed? 2 ☑/No	death?	2 □ No	
\	sician certifi rector	Be	25. Was case refe examiner?	. I	lospital:			Oth		of Death (C			Other Spec	SOW S HA	Daich
5	Physer this eral di	1: To	1 ☐ Yes 2 27. Manner of Dea	1140	1 ∐ Inpati 28a. Date of Inj	ury	28b. Time o	f 28c. Inju	ry at		5 L Resi			cny) · · · · ·	3700
VISION OF	ath. r: Afte	atio	1 Natural 2 Accident	5 ☐ Pending investigation	(Month, Da	ay, rear)	Injury	M 1 □	κ? ]Yes 2.∐N	No					
<u> </u>	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearh.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, e	jury - At ho tc. (Specify	me, farm, str	eet, factory, office		28f.	Location (	Street an wn, State,	d Number or Ru )	ıral Route Numb	er,
ב	pital o		29a. Certifier	1  ✓ Certifying Phys	nigian. To the heat	of my know	uladna dest	h occurred at the t	ima data an	d place, and	I due to the	cause(s)	and manner as	s stated.	
	Phos 24 ho Fun etely	edical	(Check only one)	2☐ Medical Exami	ner: On the basis	of examinat	tion and/or in	vestigation, in my	opinion, deal	th occurred	at the time,	date and	place, and due	to the cause(s)	
	To the vithin To the compl	Me	29b. Signature and	2				29c. Licens		_			e signed (Montl	-	
			> Ner 4	Ollu 15					1459	31		1	lay 21	2001	,
	71		30. Name and add	dress of person who co	empleted cause of	death (Item 28 3S	23a) (Type, Smu	Print) Hy Aver	ue	Balt	more	3 M	0 2120	3	
	Sta Registr		31. Date filed (Mo.	nth, Day, Year)	32/Regist	rar's Signat	1. pa	wed							
				MMI T LUU	~ /	-									

09-03918 Mark Durant Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

	State of Maryland / Department of 1- For State Certificate of Registrar	Death	2009 1667							
Physician/ ledical Examiner	Decedent's Name (First, Middle,Last)	2. Date of Deat Month May 17, 20	h 3. Time of Death							
)	Mark Durant  4a. Facility Name (if not institution, give street and number)  Prince George's Hospital Center	4b. City, Town, or Location of Death Cheverly	4c. County of Death Prince George's							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  2 2 0 - 6 4 - 9 8 2 9 1 XM 2 F 5 1 Yrs	Months Days Hours Min.	th(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)  - 5 7 M D							
any	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location	ion	10d. Inside City Limits							
<u> </u>	MD NA Baltimor		1xxYes 2 No							
ith the Maryland 23a or 28a-f sho notified at once	1647 Thomas Avenue	21216	USA							
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygrene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumarite event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Never Married 2 X Married Armed Forces? In Yes 2 X No	as Decedent of Hispanic Origin? (Specify Yes or Noves, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2X No specify:	14. Race - American Indian, Black, White, etc.  Specify: Black							
.0036 within 72 hours aft giene. her than "natural' Medical Examine ompleted by	15. Decedent's Education (Specify only highest grade completed) 16a. Deceden	nt's Usual Occupation (Give kind of work done lost of working life. DO NOT use retired)	16b. Kind of Business/Industry $ukn$ .							
21215-0036 out de filed within 7 Mental Hygiene. marked other than en event, the Medical Ce event, the Medical FO Be Comple	17. Father's Name (First, Middle, Last)	ce Clerk  18. Mother's Name (First, Middle, N	Maiden Surname)							
2121 hould be fill hould be fill hould be fill is marked is marked tite event,		g Address (Street and Number or Rural Route Num								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nati	Verta     Larkins-Sister     5504       20a. Method of Disposition     20b. Place of Disposition       1XXBurial     2 Cremation     3 Removal from State	E. Boniwood Turn C sition (Name of cemetery, her place)  Date	1 inton, MD 20735  20c. Location - City or Town, State							
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite injury or other tr	4 Donation 5 Other Specify: Mt. Zion	n Cemetery 05-23-09 Name and Address of Facility Wylie Fu	Lansdown, MD neral Home P.A.							
Physician	1 / 10	88 North Gilmor Stre	et Baltimore, MD							
/Medical caminer	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic card Due to (or as a consequence of):	liovascular disease	Death							
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause									
outed nd rransit I Examiner										
50, te be executed sysician and burial - transit	X UNPENDED AMENDED 23a,27,perME,	g891 5/27/09 TT	1001 001 (11)							
box 68760, the death certificate be the death certificate be the attending physiciched for use as the buinded for use as the buinded Physician/Med	past 12 months?  4 Pregnant at time of death 5	etal death 3 Ectopic pregnancy ther (Specify)	23d. Date of delivery  Month Day Year							
P.O. Bost that the degree by the seed detached for a detached for by Physical by Physical for the seed for th	Part II. Other significant conditions contributing to death but not resulting in the		obacco use contribute to the cause of death?  s 2 No 3 Probably 4 ✔ Unknown							
cords, law require has been si 2 should to		24a. Was	an 24b. Were autopsy findings available							
Vital Recoivsician: The law his certificate has director, page 2 si	25. Was case referred to medical	1 ✓ Yes 26.Place of Death (Check only one)	2 No 1 Yes 2 No							
f Vital Physician: er this certif ral director,	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatien		Residence 6 Other:							
ision of Attending Physic death. rector: After the by the funeral ication: Tication: T	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of	Injury 28c. Injury at Work? 28d. Describe	how injury occurred							
.≥ 호텔트림 #=	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 1 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
the Ho hin 24 h the Fu npletely	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occur one)  Wedical Examiner: On the basis of examination and/or investigation and manner stated.	nred at the time, date and place, and due to the caustion, in my opinion, death occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)							
To with To con	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) May 18, 2009							
$\sqrt{}$	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21201								
State Registrar	31. Date filed (Month, Day, Year)  MAY 2 6 2009  32. Resistrar's Signature									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 **Physician** Donald Dorsey 5:46AM 19 May /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A1034 Mackleer Court Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months **X**XM 2□ F 215-52-1016 Nov.23,1949 Maryland 59 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 21 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan in a marked one. 10d, Inside City Limits 10c. City, Town or Location 10h County 10a State Wes 2 □ No N/A Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21202 USA 1034 Mackleer Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐Yes 2♥ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Demolition 9th Grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Smith James Hopper Dorsey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3549 Lyndale Avenue Baltimore, MD 21213 Michelle Johnson/ Niece Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Wilburial 2 Cremation 3 Removal from State Mt. Zion Cemetery 5/23/09 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** -Und Cancer disease or condition resulting in death) /Medical Due to (or as sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an The law cate has t page 2 sl autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 KN Residence 6 Other (Specify) 1 Tes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) DCRN

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

ap, crop

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

82. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Pleas	e Type or Pri	nt in B	lack In	delible Ink.	Ensure A	II Copies A	re Legible	<b>.</b>	
		For	State of M	aryland		artment of H		/lental Hygi	ene,	0 16678	
		State     Registrar			Cei	tificate of L	Death		g. No. 4 U U	5 10070	
Physicia /Medic		1. Decedent's Name (First, Middle, I	BRUN	IWE	2161	rT		2. Date of Death		ar 3. Time of Death	
Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or	Location of Death	RE	4c. County of D	eath	
Funeral Director		5. Social Security Number 6 213-82-1363	. Sex 7. Ag 1 □ M 2 🔀 F	ge (In yrs. la 50	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 3/26/	4050	Birthplace (State or Foreign Country) Iaryland	
pu .		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation				10d. Inside City Limits	
faryla f show	ō	MD Tob. County								1√∑Yes 2 □ No	
the A	Director	10e. Street and Number		Dd.	ltimo	10f. Zip Code		10	g. Citizen of What	: Country?	
hours after death with the Maryland turel", or items 23a or 28a-f show		3102 Walbrook	Avenue			21216			USA		
death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.\	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-		American Indian, /hite, etc.	
after or ite		1 ☐ Never Married 2 🙀 Married		No		ires, specify cuba 1 ∐Yes 2 <b>∏</b> No	Specify:	Trican, etc.)			
72 hours "natural",	d by	3 Widowed 4 Divorced	Year or Dates:						Specify: E		
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Aenta Aenta rked tic ev	일	Frank Drumwri	aht				Gladys_	Edwards			
and h		19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, Sta	te, Zip Code)	
and and and m 27		Tiffanv Matth	ews/daugh	ter	2644	Boone S	treet B	altimor	e, MD 2	21218	
ges 1 If itel or otl		Tiffany Matth 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐ Removal from State								
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permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other traumatic event, in the first one.		21. Signature of Funeral Service Lie	ensee .			. Name and Addres	cha chilly Cha	atman-Ha	arris Fu	uneral Home	
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Physisian		shock, or heart failure. List or Immediate Cause (Final	ly one cause on each I	ine.	neel	-/20		nona		Interval Between Onset and Death	
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after after Direction b	Certification:	4 ☐ Homicide determin	building, e	tc. (Specif	y) .	eet, factory, office		City or Town	, State)		
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes kaminer: On the basis and manner s	of examina	wledge, deat tion and/or ir	th occurred at the tin	me, date and place opinion, death occu	e, and due to the caurred at the time, da	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)	
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DHMH 17 Rev 1/2001

			For State Registrar	State of Ma		epartment of Certificate		and Menta		ne No. 2	009	161	679
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	ъ		Usual Residence of Decedent					10127	12/13	-			
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36	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, I're Medical Evanirar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced	Armed Forces?		If Yes, specify 1 ☐ Yes 2 🔀	Cuban, Mexicar	n, Puerto Rican,	etc.)		Black, White, e	etc.	
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Baltimore,	permit. Pages Department or Important: If I any Injury or		21. Signature of Funeral Service L	censee	5	22. Name and A 5305 Har		GOOM	rd J. timore	Ruck , MD	, Inc. 21214		
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. O. Box	the death certificate be executed by the attending physician and tched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic preg 5 ☐ Other (speci					Date of delive Month	,	/ear
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)	Vithii To th	Me	29b. Signature and title of certifier	=M2	27	29c. L	cense number	45%	290	Date sig	gned (Month,	Day, Year)	9
		(	20. Name and address of person w	ho completed cause of de	eath (Item 23a)	(Type, Print) -	Jal &	) SWR.	6/20	B	Wmie,	Mul-2	1061
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 2009 Charles Dunphi Mac 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Bayview Medical Center Johns Hopkins Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/13/1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 78 Yrs. Days Hours Min. 1**№** M 2□ F MD 212-30-0372 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1XIYes 2 □ No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21224 USA 803 South Dean Street 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No
If Yes, Give US Marines 1 Yes 2 Xo
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Sheet Metal Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 803 S. Dean Street, Baltimore, MD 21224 Beatrice J. Dunphy / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Ardent Crematory or other parties of the control of 1 ☐ Burial 2 ☐ Kremation 3 Removal from State 05/25/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall Moustial 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days Preumonia Due to (or as a consequence of): Mesotheliomo Due to lor as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, 17 s. Medical Examinar must bu nutfind at once.

Baltimore, Maryland 21215-0036

Examiner

the signed by to be detach page 2 should has After this certificate Hospital or Attending Physician:

law requires that the death certificate be executed

The

Box 68760,

P.O.

Records,

Division of Vital

attending physician and for use as the burial-trar 24 hours after death. e Funeral Director: A

Physician/Medical þ Completed Be မ Certification: completely filled in by the

29a. Certifier

29b. Signature and title of certifier

Dara Neuman-Sunshine

Medical within 2 To the I

State Registrar

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 1 Xinpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, Hayland

29d. Date signed (Month, Day, Year)

23,2009

21224

DHMH 17 Rev 1/2001

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mome MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 4 U 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 9! Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F -20-9314 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event any injury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Director New York 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt. 19 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 ☑ No Specify. <u>۾</u> 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ avi 19b. Mailing Address (Street and Number or R 1 Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. rint) daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part/l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mosclenot Physician /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed w tenju attending physician and for use as the burial-tran Due to (of as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Year Month Dav in the past 12 months? 1 □Yes 2 □No 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 🗹 Unknown 2 No 3 Probably 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 🗷 No Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Man or of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day,

Year)

gistrar's Signature

W.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 23 **Physician** 5:30 A M 2009 Theresa Davis May /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Owings Mills 438 Garrison Forest Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 □ M 2 🔀 F 84 1925 Missouri 220-30-7177 17, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Illudical Examination and example. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ▼ No Directo Owings Mills Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21117 438 Garrison Forest Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 No Completed by 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marv Adelaide Grome Malcolm McMenamy မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3114 Caves Road, Owings Mills, Maryland Gregory Davis / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 05-27-2009 Towson, Maryland 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 1050 York Road, Towson, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final UNG car **Physiclan** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and -trar Due to (or as a consequence of) the attending physician a ned for use as the burial-t P.O. Box 68760 Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 DNo 9 Unknown 9 Unknown ò 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 certificate 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes မ this 24 hours after death.

Funeral Director: After the letely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide completely filled 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

n, Day, Year) 32. Régistrar's Sigha

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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month V 25 <sup>Day</sup> 2009 Year **Physician** May 6:00 A M Paul Kenneth Dell Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Lutheran Village If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11-18-1948 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Pennsylvania 1**%** M 2□ F 60 217-48-3231 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Carroll MD Westminster 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21157 USA 796 Mountain View Dr. 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ð 3 Widowed 4X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired Engineer I Hygiene. Elementary/Secondary (0-12) Waste Water Treatment Industrial n and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Kenneth Dell Sr. Wilda Condon Dell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 796 Mountain View Dr. Westminster, MD 21157 Matt Dell-son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Kriders Cemetery 6-1-2009 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur VEur eral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home, PA 254 E. Main St. Westminster, MD 21157 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Chronic Obstructive Pulmonary Disease Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dire to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed and Due to (or as a consequence of) burial-Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ģ 5 Other (specify) signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>Ş</u> Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No certificate 1 ☐Yes 2 No 1 □ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 🗋 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature an d title of certifier 2009 H0055845 KINGS DRIVE Name and address of person who completed cause of death (Item 23a) (Type, Print) BREWSTER TANEYTOWN, Md. 31. Date filed (Month, Day, Year) Registrar's Signature State park Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 9 ame (First, Middle, Last) 2. Date of Death

1. Decedent's Name (First, Middle, Last) 3. Time of Death Month May **Physician** 2009 6:24 P M Janet Elizabeth Fletcher /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 7923 Springway Road Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 4, 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🗓 F 82 161-20-1377 **Director** Usual Residence of Decedent 10d. Inside City Limits f show 10a, State 10c. City, Town or Location r than "natural", or items 23a or 28a-f shoon than "natural Evan, ingression to motified at 1 □ Yes 2 No Director Baltimore Maryland Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21204 **USA** 7923 Springway Road permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Event in the conce. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: à 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John B. Gotwalt Fannie Mae Ely ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7923 Springway Road Towson, MD 21204 William Todd Fletcher, Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metro Crematory Inc. | 05/26/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5×15 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-t Due to (or as a consequence of): P.O. Box 68760, ned by the attending physician detached for use as the buria death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by to The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown ASCUIZE 1 ☐ Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D19503 5-26-09 10 Gerardaved19 Timonium MD21093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWARD P. COSTLOWAD I COSTLOW 40 31. Date filed (Month, Day: Year)

State Registrar 31. Date filed (*Month*, *Day*, Year) — **MAY 269** 



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_		For State Registrar	te of Maryland		rtment of H tificate of L			eg. No. 2009	16685
	Physicia		1. Decedent's Name (First, Middle, Last)	Lawrence	Willia	m Fra	ınk , Sr.	2. Date of Deat Month May 1	Day Year	3. Time of Death  1:52 A
	/Medio		4a. Facility Name (If not institution, give street a	nd number)		4b. City, Town, or	Location of Death		4c. County of Dea	
			Johns Hopkins Bayv				imore Ci	V	N/A	
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 [	7. Age (In yrs. la.	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July 27	Year) C	rthplace (State or Foreign ountry) ryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	Mary I sh	tor	Maryland Balti	more		Du	ında1k			1 ☐ Yes 2 🛣 No
	h the	irec	10e. Street and Number		W- W	10f. Zip Code		1	0g. Citizen of What C	ountry?
	ath wif	ral	2001 Larkhall Road				21	222	United Sta	ates
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be notified at once.	d by Funeral Director	1 Never Married 2 Married 1 If Ye	s Decedent Ever in U.S. ned Forces?  Yes 2 [ <b>X</b> No es, Give Ir or Dates:		/as Decedent of Hi Yes, specify Cubai □Yes 2 👿 No		pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
5-0	72 h	etec	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Deced (Give I	ent's Usual Occupa ind of work done d O NOT use retired	ation Juring most of work	ring	16b. Kind of Business	/Industry
121	within ene. than	Completed	Elementary/Secondary (0-12) Col 7 Years	lege (1-4or 5+)		o NOT use retired; right			Steel Inc	de observ
d 2	filed Hygin	ပိ	17. Father's Name (First, Middle, Last)		MILLIW	11911	18. Mother's Nam	e (First, Middle, I	Maiden Surname)	ustry
lan	ild be fental rked c	To Be	John	Frank			Adabelle	2	Lat	ham
ary	shot and N s mal		19a. Informant's Name/Relationship (Type. Prin	nt)	19b. Mailing	Address (Street a	and Number or Ru	ral Route Number	; City or Town, State,	Zip Code)
Σ	and 2 ealth n 27 i		Margaret Frank (daught	er in )		9 Melbou:			, Maryland	
ore	ges 1 t of H If iter or oth		20a. Method of Disposition  1 ☐ Burial 2 ★ Cremation 3 ☐ Remova	from State		ition (Name of atory or other place			20c. Location - City o	
ţi	t. Pac rtmen rtant: njury		□ Donation 5 □ Other (Specify)	Hil		ervice Co		26/2009	Towson, M	
Bal	Deparement		21. Signature of Funeral Service Licensee	100		922 Wise			Funeral Ho Md 2 <b>12</b> 22 D	me or undalk, Inc.
		4	23a Part . Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. e on each line.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death)	CUTE MYO	CARDIA	IL INFA	RCTION			Onset and Death
	/Medical Examiner			ue to (or as a conseque		a Kinazi i Ta	000.0			
		ē	Sequentially list conditions, if any, leading to immediate	RONGRY JRT ue to (or as a conseque	-	HEROSCUE	KM217			
fr	cuted nd ansit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
, ,	icate be executed physician and the burial-transit	edical Examiner	resulting in death) Last	ue to (or as a conseque	ence of):					
68760,	cate b	dica	d							
Box 6	leath certific attending p			es, outcome of pregnan		Est. 1			23d. Date of de	elivery
P.O. B	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/N	1 Dve 2 DNo	] Live birth 2 ☐ Fetal of ] Pregnant at time of dea ] Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
σ,	law requires that the deas been signed by the		Part II. Other significant conditions contributing	g to death but not result	ting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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ecc	<b>sician</b> : The law requ certificate has been rector, page 2 should	Completed by	HYPERLIPIDEMIA					24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
<u>=</u>	: The icate I							perfori 1 □ Yes	med? death? 2 No 1 ☐ Ye	s 2 🗆 No
Z.	siclan certif rector	Be	25. Was case referred to medical examiner?	:		3 🗆 DOA Othe	26. Place of Dea			
of	Physer this eral di	5	I Tes ZIAINO	1 Inpatient 2 LE	R/Outpatient 28b. Time of	28c. Injury	at Nuising 11		ence 6 Other (Sp ow injury occurred	ecify)
ion	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Work	? ′es 2 □No			
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
_	Hospita 24 hours Funeral tely filled	Medical C	29a. Certifier (Check only (Check only 2 Medical Examiner: On	the basis of examination						
15	To the within ? To the comple	Med	one) and 29b. Signature and title of certifier	d manner stated.		29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)
•			30 Name and address of name in	d cause of death (Ita-	23a) /Tuma 5	D DOS	4244		5/19/	2009
			30. Name and address of person who complete Christopher Zajac, M	.D. 9649 Be	el Air	Road Su	ite 200	Baltimo	ore, MD 2	1236
	Sta Registr	te ar	31. Date filed (Month, Day, Year) NAY 26 2009	32. Registrar's Signatu	1. 40	ake				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2.50-AM James Μ. Frome Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ANNE BALTIMORE WASHINGTON GLAN MEGLAC CENTER **BURNIE** 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours Min 1**X** M 2□ F 17 1934 Maryland 213-34-7345 Nov. Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Maryland 1 ☐ Yes XXNo Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21060 1001 Stane Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes Give X 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) 11 <u>Illustrator</u> Contracting Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest J. Frome Anna Hodek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sandra L. Giunta/Daughter 392 Phirne Road Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 5/26/2009 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services, PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 ACTROINTESTINAL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as e consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ,2 🗹 No 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the detached i has certificate this After 1 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Director

Funeral

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Completed

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Certification: To

Medical

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medical

4 Homicide 29a. Certifier

6 □ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

d address of person who completed page of dea 1000

31. Date filed (Month, Day,

Registrar's Signature

State

Duane 09-04065	Fuller
UNK UNK	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	(	Certificate	of Death		Reg.		0001
Physic	ian/	Decedent's Name (First, Middle,Last)	*				Date of Death     Month	ay Year	3. Time of Death
Medical Exam	iner		F. Ful	ler	Table City Taylor	Leaties of Death	Month D May 22, 200	9 4c. County of Deati	0445 hrs
		4a. Facility Name (if not institution, given 1616 Cape Horn Road	ve street and number)		4b. City, Town, or Cape Horn	Location of Death		Carroll	
Funera		Social Security Number     6. S	ex 7. Age (In	yrs. last birthday	If Under 1 Year Months Days		8. Date of Birth(	MM/DD/YYYY) 9. Bit Forei	gn
Director			ζ M 2 F		Jan 10,	, 1970 Co	ountry) MD		
any		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
* .		MD Carro		7,	Mancheste	20			1 Yes 2 X No
Maryland 28a-f show d at once,	cto	10e. Street and Number	11		10f. Zip Code	1	10g	. Citizen of What Cou	Intry?
5-0036  ed within 72 hours after death with the Maryland fygiene other than "matural", or items 23a or 28a-f sho the Meical Examiner must be notified at once.	Director	2608 Susanan	n Drive		211	0.2		U.S.A.	
with with us 232	ral	11. Marital Status	12. Was Decedent Ever		Was Decedent of His	panic Origin? ( Sp		14. Race - Amer	rican Indian, Black,
death or iten	Funeral	1 Never Married 2 X Married	Armed Forces?		If Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	White, etc.	
			If Yes, Give Year or Dates:	1	Yes 2 X No				White
hours 'natu	ted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	ed) 16a. Dece durin	dent's Usual Occupat g most of working life.			6b. Kind of Business	Industry
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner.	Completed	Elementary/Secondary (0-12)	2		Vice P	resident		Sunrise S	Safety Ser.
5-003 iled withi Hygiene. d other th	Son	17. Father's Name (First, Middle, Las				18.Mother's Name	(First, Middle, Ma		Jarce, Ber.
	Be (	Daniel	H. Full	er		R	ebecca :	Knop	
ID 21 should and Me 27 is mar	유	19a. Informant's Name/Relationship (	Type, Print )	19b. Ma	iling Address (Stree	et and Number or F	Rural Route Number	er, City or Town, Stat	e, Zip Code)
≥ 5 5 5 5		Stacey L. Fuller 20a. Method of Disposition			Susanann position (Name of cer			er, MD 21	
Baltimore, Nermit. Pages I and Department of Health Important: If item injury or other frau		1 X Burial 2 Cremation 3	Removal from State	crematory o	other place)	- 1		ŕ	
timent trant:		4 Donation 5 Other Specify			d Cemeter			Hampstead,	
Baltimo permit. Page Department of Important: injury or otd		21. Signature of Fundry Service Lice	Dege C		2. Name and Address	11		terstown H	
Physiciar	J	23a. Part I. Enter the disease, or com	plications that caused the c		ELINE FUNE er the mode of dying,				21136 Approximate Interval
/Medica		failure. List only one cause on e	ach line.		and therm				Between Onset and Death
xamine	i	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequer		and therm	ar mur	168		
		Sequentially list conditions,							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequer	nce of):					
=	хац	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):					1
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760, cate be ex physician he burial	/Medical	X UNPENDED	AWILINDED			.072 0/17	703 11		
the se		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of 1 Live birth	pregnancy 2	Fetal death 3	Ectopic pregna	incy	23d. Date of delive Month	ry Day Year
Box 68's death certiff he attending do for use as	Physician	past 12 months?	4 Pregnant at time		Other (Specify)				
BO) Re deatl the att		1 Yes 2 No 9 Unknow	9 Unknown				Les pilles		0
i, P.O. B ires that the d signed by the l be detached	by F	Part II. Other significant conditions	contributing to death but	not resulting in t	ne underlying cause g	given in Part I.	1 Yes	acco use contribute to	bably 4 V Unknown
duires quires en sig uld be	ted		<del>.</del>				24a. Was ar		utopsy findings available
cords. law requir	Completed						autopsy	prior to	completion of cause of
tal Rec sian: The certificate	Co						1 <b>✓</b> Yes 2	No 1 🗸	res 2 No
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpat		Other Nursin		esidence 6 🗸 Oth	or: Soono
		1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time		ry at Work?		w injury occurred	er. Scene
ion of tending Pheath.  Incr: After the funeral	tio l	1 Natural 5 Pending	(Month, Day,Year)	0 E4 0	445 hrs	Yes 2X No	subject	injured :	in fire
	fica	2 X Accident Investiga 3 Suicide 6 Could no	28e. Place of Injury	At home, farm,	treet, factory, office t	ouilding, etc.	28f. Location (St	reet and Number or F	Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire	Certification:	Suicide Could no determine	oth (Specify)	er			or Town, Sta Manchest	er, MD	e Horn Kd
Divis  Divis  To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier (Check only one) 2 Medical Examine	cian: To the best of my known:	owledge, death o	ccurred at the time, da	ate and place, and	due to the cause at the time, date ar	(s) and manner as stand place, and due to	ated. the cause(s)
To the complex	Medical	29b. Signature and title of certifier	and manner stated.	1 0	29c. Licens			29d. Date signed (M	
		10/11	1		O.C.	M.E.		May 22, 2009	
		30. Name and address of person who	completed cause of death	(Item 23a)					
		Zabiullah Ali, M.D. Ass	istant Medical Exam		enn Street, Balt	timore, MD 21	201		
	tate	31. Date filed (Month, 6a) 2009	32. Registrar's 9	gnature	1			. 479	
Regi	strar	MAIRO	June 10	CF			00	ME	

	Apr		State of Maryland / Dep		lental Hygien	e <sub>2009</sub> 15688
		-	- State Registrar Ce	rtificate of Death	Reg. No	
	Physicia	an.	1. Decedent's Name (First, Middle, Last)		Date of Death     Month     Date	
	/Medic	al	Beverly Esther Goodman	1	MAY IS	c. County of Death
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		Prince George's
			Doctors Community Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Lanham If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	9. Birthplace (State or Foreign
	Funeral		5. Social Security Number 053-22-0788 6. Sex 1 □ M 2 \ F 81 7. Age (In yrs. last birthday, 81 Yrs.	Months Days Hours Min.	(Month, Day, Year Aug. 26, 1	927 New York
	Director	.	Usual Residence of Decedent			
	yland		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	a-f st	ctor	Maryland Anne Arundel Churchto	n		
	or 28	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	th wil		1017 Rodgers Road	20733		S.A.
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Evarificar must be putified at	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or i		1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 □ Divorced Year or Dates:	1 ☐Yes 2 X No Specify:		Specify: White
9	hour tural	Completed by	15 Decedent's Education 16a Dec	edent's Usual Occupation		Kind of Business/Industry
15	in 72 n "na Nedic	plet	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing	
21215-0036	with giene r tha	E	12 Telep	hone Service Rep.		ommunications
b	othe othe	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	en Surname)
Maryland	uld by Menta Irked Itic e	10	Jacob Goldman	Rose Eps		
lar)	2 sho and 1 is ma		,	ing Address (Street and Number or Rui		
≥, ≤	and and n 27 n 27	133		Rodgers Rd., Chur	chton, MD	20733 Location - City or Town, State
ore	ges 1 t of H if itel			ematory or other place)		•
Ë	tmen tant: jury		4□Donation 5□Other (Specify) Metropo1	itan Crematory 5-1	8-09 Ale	exandria, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evertired must be a culffled at once.		21. Signaturi / Funeral Service Licensee	22. Name and Address of Facility Beth Shalom Memori 640 Lee Rd., Orlar	al Chapel	310
	HD = 10 G		23a. Part . Enter the disease, or complications that caused the death. Do not e			Approximate Interval Between
1	Medical Examiner  bhysician and sthe burial-transi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			
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O. Box	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
о, С	requires that the leen signed by th nould be detache	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
rds	quire en sig uld b	ed			1 ☐ Yes	2 No 3 Probably 4 Unknown
Vital Records,	8 8 8	Completed by			24a. Was an autopsy performed 1 □ Yes 2	
ta	, <i>iò</i> <del>C</del>	Be C	25. Was case referred to medical	26. Place of Dea	ath (Check only one)	
<u>&gt;</u>	Physician: r this certific ral director,		examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpat	ient 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence	e 6 Other (Specify)
Division of	ding Ph h. After th funeral	Certification: To	27. Manner of Death 1 Manural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	/ Work?	28d. Describe how in	njury occurred
Sio	Attending r death. Sector: After on the fune	cati	2 Accident investigation	M 1 Tyes 2 No	28f Location (Street	t and Number or Rural Route Number,
iVi	or At after d Direct in by	ıtifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, Si	tate)
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.			
b	To the within 2 To the complet	Mec	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	F 3 F ŏ		Den Da a mo	MDD 61637	0	5-15-09
			30. Name and address of person who completed cause of death (Item 23a) (Type CAMEO COZART 81/8 Goo	29c. License number  MDD 61637  e, Print)  Luck Road, L	ANHAM M	40 20706
		ate	31. Date filed (Month, Day, Year) 32/Registrar's Signature	harry		
	Regist	rar	MAY 26 2009 Server B. A			

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GOODMAN

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month PM MAL P505 BOBBIE 18 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5-23-1960 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 X F 214-82-4597 48 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County Yes 2 No N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21224 USA Clinton Street 414 N. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1X Never Married 2 Married Black 1 Yes 2 No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled 9th grade Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gibson Oceluía Robert Gladney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 414 N.Clinton Street Balto, MD 21224 Oceluia Gladney-Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State King Memorial Pk 5-23-2009 MD Randallstown, 5 Other (Specify) 4 Donation 22. Name and Address of Facility March East 21. Signature of Funeral Service Licensee Milw MD 21202 1101 E. North Avenue Balto, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (r as a consequence of): hoz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due o (or as a consequence of) bue to (or as a consequence of): resulting in death) Last human Vivan IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year Yes 2 No 9 □ Unknown in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-trai Division of Vital Records, P.O. hæ certificate I Director: After the after the Hospital

Examiner Physician/Medical þ Completed Be မ Certification:

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show notified at

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Department of H Important: If ite any injury or otl once,

Physician

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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within 24 hours a

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2 🗌 Accident

3 
Suicide 4 🗌 Homicide

(check only one)

29a. Certifier

Could not be determined

and address of person who completed cause of death (Item 23a) (Type, Print)

MD PhI MON 32. Registrar's Signature

and manner stated

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

RES-000

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 Yes 2 No

29d. Date signed (Month, Day, Year)

2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

		State of Maryland / Department of Health and Months    1 - State	ental Hygien Reg. N	711114	16690
		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Da		3. Time of Death
Physici /Medio			MAY 22	2009	7.15 P. M
Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  ALTIMORE WASHINGTON MEDICAL CENTRE  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24 Hrs.	RME F	County of Death	ARUNISEL  hplace (State or Foreign
Funeral Director		5. 362 1 M 2 F 66 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year May 16, 1	943 Ore	gon
ס		Usual Residence of Decedent			10d. Inside City Limits
faryla Fshov	ō				1 ☐ Yes 2 ☐ No
r 28a-	Director	MD Anne Arundel Glen Burnie  10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Co	untry?
th with 23a o	alD	106 2nd Ave SW 21061		USA	
er dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto for the Company of the Co	city Yes or No- Rican, etc.)	14. Race - Ame Black, White	
hours after ural", or i	by F	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 📆 No If Yes, Give 1 ☐ Yes 2 🖼 No Specify: Year or Dates:		Specify: V	Thite
72 hou	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working the complete of the complete o		Kind of Business/	Industry
vithin vithin in the same in t	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Landscaper		Constru	iction
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wild be file Mental Hy arked oth	To Be	Taul dettie	cDonald		
d 2 should be filed within 72 hours after death with the Maryland d 2 should be filed within 72 hours after death with the Maryland in and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Madical Examinar must by nutified at	Ι.	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rura			Zip Code)
Health		THIS. Flat that Other William of Dispusition (Name of	Burnie, MI	Location - City or	Town, State
ages ent of rt: If its	Ш	20a. Method of Disposition  1 Burial 2 Archaetion 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Atlantic Crematory  200	25, 9 G1	len Burn:	ie, MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the cultilled at once.		21. Signature of Funeray Service Linensee  MO1220  Services 1 2nd Ave	gleton Fur	neral &	
	-	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of			Approximate Interval Between
Physician	8 0	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of):	20		
Laminer	ē	Sequentially list conditions, I b. MEACTATIC POSTATE CANCE	<del>-</del>	3	
cuted Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  c.			
cate be executed physician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			
icate be executed physician and the burial-transit	dical	d			
ath certifi attending or use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of de	•
death death a atte	sicia	in the past 12 months?  1		Month	Day Year
at the d by the etache	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
uires th	Completed by			2 □ No 3 □ P	
he law require he has been si ge 2 should b	lete		24a. Was an	24b. Were a	utopsy findings available completion of cause of
The la	l E		autopsy performed 1 🗆 Yes 2 🖃	?/ death?	
VILCI ician: T certificat ector, pa	Be C	25. Was case referred to medical 26. Place of Death	h (Check only one)		
Physic This c	2	1 ☐ Yes 2 ☑ No ☐ Normal 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ 4 ☐ Nursing Ho	me 5 Residence		ecify)
ding th.: After	tion	27. Man r of Death 1 ➤ Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 □ Accident investigation		,,	
I or Attending after death. Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St		lural Route Number,
To the Hospital or Attending Physician: The law requires that the death certification of the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending I to the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical C		and due to the cause red at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
To the Youthin To the Complex	Me			Date signed (Mon	th, Day, Year)
		10 See 29 W) 245149	MY	ay 22	2009
		30 Name and address of person who simpleted cause of death (Item 23a) (Type) Print)  ABA TO TO HOS PIRAL ON YE GLEN B	whie	Mis !	20161
St. Regist	ate trar	31. Date filed (Month, Part Yes 2 6 2009 32. Resistrat's Signature S. Apark			

			1 - For State Registrar	State of Maryland		artment of Hortificate of L			giene 009	16691
ī	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Year	
	/Medic	al	Emily Gosnell  4a. Facility Name (If not institution, give st	reat and number)		4b. City, Town, or	Logation of Door	May	22 2009 4c. County of Dec	5:50 AM
310	Examin	er	Transitions Health			Sykesvill		n	Carrol1	101
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	if Under 24 Hrs Hours Min.		9. Bi	rthplace (State or Foreign
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	rland ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-feh	ctor	MD Carroll	Sy	kesvi	11e				1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	e 23e	Funeral	2810 Kaywood Plac	e 2. Was Decedent Ever in U.5	2 12 1	2178		Propin Vos or No	14 Raco Am	USA perican Indian,
30	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mentai Hygiene. If Ifem 271s marked other than "natural", or Iteme 23a or 28e-1 ehow or other treumatic event, it a Madical Examinational Leading at	by Fun	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Amed Forces?  1 Yes 25 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar I ☐ Yes 2XXNo	Specify:	to Rican, etc.)	Specific	ite, etc.
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Ž	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	`life. I	DO NOT use retired)	uring most of wo	rking		
	filed within Hygiene. Ither than "		12 17. Father's Name (First, Middle, Last)		Book	keeper	18 Mother's Na	me (First, Middle,	Gosnell 1	Builders
yland	ld be i enta! ked o lc eve	To Be	Valentine Thompso	n				volbeski	maiden damame,	
ary	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street a			r, City or Town, State,	Zip Code)
e, E	and 2 ealth a m 27 la		Dorothy Gillespie						stown, MD	
o ce	ges 1 it of H if Itel		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Re	moval nom State		sition (Name of natory or other place	1	Date	20c. Location - City of	
Saltimor	t. Pa rtmer rtent: njury		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Signature			Mem. Par	1	7/2009	Sykesville	
ם ח	Depermine Depermine Depermine Depermine Depermine Depermine Depermine Department of the Department of		Code A feet	Our	1	212 W. 01	d Libert	y Rd., W	e & Cremato Vinfield, M	
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Ĺ	s that ned b	by Pr	Part II. Other significant conditions contri	ibuting to death but not resu	Iting in the ur	nderlying cause give	n in Part I,	23e. Did 10	bacco use contribute	to the cause of death?
cords,	equire en sig ould b	edt						1 🗆 Y	es 2⊡No 3⊟F	Probably 4 Unknown
ב	The law rate has be	Completed						24a. Was a autop perfor	sy prior to med? death?	
<u>a</u>	clen: ertific ector,	Be	25. Was case referred to medicat examiner?					ath (Check only or		
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DIVID	of or Atterest of the other ot	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al hor building, etc. (Specify,	ne, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and Number or I n, State)	Rural Route Number,
	To the Hospitel or Attending Physicien: The lave within 24 hours efter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	cian: To the best of my know or: On the basis of examinati and manner stated.	on and/or inv	estigation, in my op	inion, death occi	urred at the time, o	date and place, and du	ie to the cause(s)
	with To t	Σ	29b. Signature and title of dentitier			29c. License	3725	2	S 22	nth, Day, Year) LCS 2/157 1)ty
5	V		30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Caye	Row	1 We	stonin	1)42
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	h /					
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			For State Registrar		State of Ma	aryland		rtment of <i>tificate o</i>				giene Reg. No.	Z 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	16692
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en g	/Medic Examin		4a. Facility Name (If not inst			Cer	nter	4b. City, Town	or Location	on of Death			County of Dea	
	Funeral Director		5. Social Security Number 219-10-8028	6. 8		e (In yrs. le	ast birthday) Yrs.	If Under 1 Yea Months Day		der 24 Hrs.	8. Date of Birt (Month, Da	h y, Year) 1925	9. Bir	thplace (State or Foreign ountry)
	ס		Usual Residence of Deceder				, Town or Lo	ration						10d. Inside City Limits
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	th the or 28a e notifi	Director	10e. Street and Number		2			10f. Zip Code				10g. Citiz	en of What Co	ountry?
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36	be flied within 72 hours after death with the Maryland tall Hygiene. tal Hygiene. do other than "natural" or items 23a or 28a-f show event, the Madical Evanian mant be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐  3 ☑ Widowed 4 ☐ Divo		12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:			Was Decedent of fYes, specify Co I □Yes 2★\			ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify:	
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ė.	es 1 and 2 of Health fitem 27 i r other tra		PAMELA GROVE 20a. Method of Disposition	•		20b. Pl	lace of Dispo	FOXGLO\ sition (Name of natory or other p			DDLE R	20c. Loc	_MD_2 cation - City or	1220 Town, State
ltimore,	Pages ment of ant: If its ury or o		1 💢 Burial 2 □ Crema 4 □ Donation 5 □ Oth			1	DWNSVI	LLE VET.	CEM.	5/29	/2009	CRC	WNSVIL	LE. MD
Balt	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Se	vice Li	msee MO1	139	22	. Name and Add	ress of Fa	Cility THE VEN BL	JOHNSO	ON FU		HOME, P.A. 21286
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Divisio	al or Attendir s after death. I Director: A: d in by the fu	Certification:	3 ☐ Suicide 6 ☐ C	vestigatio ould not b etermined	18 Place of Inju	ury - At ho c. (Specif)	ome, farm, str y)				28f. Location (. City or To			Rural Route Number,
_ ; ; ;	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p	Medical Ce			hysician: To the best of miner: On the basis of and manner sta	f examina								
	To the vithin 3	Me	29b. Signature and title of co	ertifier	1//			29c. Lice	ense numb	er		29d. Dat	e signed (Mor	nth, Day, Year)
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			30. Name and address of per IMRAN SIDI					Print) R DRIV	Entre 170	(711622)	a wysny	/ 1 /5k!v	\ \	h ()
	Sta	te	31. Date filed (Month, Day,	Year)	32. Registra	ar's Signa	ture		less 1	UWSUI	V. MARY	L. HIVL	<u>/ [1.154</u>	s arg.
	Registr	ar	MAY 26	2009	Carreta	8.	back							

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Dorothy E. Gaylord May 18, 8:30 P.M 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Commons Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 M 2 X F 219-38-0467 67 Director June 21, 1941 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3310 Benson Avenue 21227 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tyes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin L. Trott Dorothy Scott ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Green Daughter 1703 Fallsway Drive; Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 5/23/2009 | Pikesville, MD 22. Name and Address of Facili Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 2122 21. Signature of Euneral Sanda Life 21C # MO1537 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** retustate c lung Conces /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed and Due to (or as a consequence of) ed by the attending physician detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2█No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 500 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 2 ER/Outpatient 3 DOA 1 | Inpatient Certification: To this s after death.

I Director: After this d in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 2 ☐ Accident Injury 5 Pending investigation 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital within 24 hours a To the Funeral I 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Da7683 21/39 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 25 Main Street MD 31. Date filed (Month, Day, Year) MAY 2 6 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7:30 AM May Poos Edith Charlein Holdcraft 20 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Levindale Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Hours Days 1 ☐ M 2 🖾 F 2, Maryland 212-32-5158 Nov. 1934 74 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐Yes 2 No Catonsville Maryland | Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 402 Forest Lane 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 □ Never Married 21x Married 1 ☐ Yes 2 🔀 No White Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martin Luther Bassford Melva Clara Wheeley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Forest Lane; Catonsville, MD 21228 Husband John Holdcraft Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 5/25/2009 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke 21. Signature of uneral Service License Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Stage Liver End disease or condition resulting in death) Due to (or as a consequence of): 3 months lotal Parenteral Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 7 months 55tula Entena Due to (or as a consequence of): Obstruction Bower Small Medical Certification: To Be Completed by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician for use as the buria certificate

To the Hospitai or within 24 hours a To the Funeral I

**Physician** 

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the M-dical Examiner must be notified at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other i any Injury or other traumatic event, <u>tt</u>

**Physician** 

Examiner

/Medical

Director

Funeral

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Completed

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Examiner

death with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

9 ☐ Unknown			OTHER OTHER						
	nikal V	,		ulting in the und	erlying	g cause given in Part I.			se contribute to the cause of death?
				<del>_</del>			.	24a. Was an autopsy performed? 1□ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case refer	red to medical					26. Place of De	eath <i>(Cl</i>	neck only one)	
examiner?	No	Hospital:	1XInpatient 2□	ER/Outpatient	3 🗆	DOA Other: 4 Nursing	Home	5 ☐ Residence 6	□Other (Specify)
27. Manner of Death Natural 2 Accident	h 5 Pending investigation	28a.	Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d.	Describe how injury	occurred .
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of injury - At h building, etc. (Speci	ome, farm, stree ty)	et, fact	ory, office	28f.	Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier	12 Certifying Phy	sician:	To the best of my kno	wledge, death o	occurr	ed at the time, date and place	ce, and	due to the cause(s)	and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D68054

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

20. 2009

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D 2434 But timore 40 HUR West Belvedere Avenue

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

acks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per dyr 8891 5-26-09 yt
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Yvonne Darnella Harrison 10:35 AM 19, May 2009 /Medical 4a. Facility Name (If not institution, give street and number)
1102 Druid Hill Ave. 4b. City, Town, or Location of Death 4c. County of Death Examiner #705 Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min Months Days 1 □ M 2 💢 F 51 Director 217-66-3250 March 5,1958 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Examinar must be maithed at MD N/A Baltimore 1XXes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1102 Druid Hill Ave. #705 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: þ If Yes. Give Specify: Black 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) year Supervisor Security Pages 1 and 2 should be filed v ment of Health and Mental Hygie ant: If Item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Emile Frances Childs ည 19a. Informant's Name/Relationship (Type. Print)
Shenelle Frasier/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8903 Waltham Woods Road D Parkville, MD21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or or 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/23/09 Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for Ö 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has performed? certificate 100 1 ☐Yes 2 ☐Nô 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☑ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 To the I and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Ifem 23a) (Type ita State Registrar

09-04067 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 16696 Jane Miller Heim State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 22, 2009 0632 hrs **Medical Examiner** Jane M. Heim 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard 4601 Dower Drive Ellicott City If Under 24Hrs. 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) NJ Months Days Hours Min Director Nov. 15, 1943 006-42-7319 M 2 X F 65 Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Yes 2 XXNo Ellicott City Howard "natural", or items 23a or 28a-f show Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 21043 4601 Dower Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. death v 1 Never Married 2 X Married Armed Forces' Yes 2 X No White Yes 2XX No specify: Specify: hours after Give Yea Widowed Divorced \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) National Institute Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lenet of Health and Mental Hygiene.
Iant: If item 27 is marked other than "n
or other traumatic event, the Medical E MD 21215-0036 of Health 4 Chemist 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert A. Miller Mary (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4601 Dower Drive Ellicott City, MD 21043 Mr. William Heim / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition fimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: I 5/26/2009 Parkwood Cemetery Baltimore, MD 4 Donation 5 Other Specify: 21. Signature of Fune of Service Licensee 22. Name and Address of Facility 5305 Harford Rd. Baltimore, MD 21214 Baltimore, Leonard J. Ruck, Inc. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease tamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** signed by the attending physician be detached for use as the burial Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 V Probably 4 Unknown diabetes mellitus Completed page 2 should 24b. Were autopsy findings available peen 24a, Was an prior to completion of cause of autopsy performed? death? ✔ Yes 2 1 1 Yes

Records, P.O. Division of Vital

certificate has Hospital or Attending Physician: funeral director this After To the Funeral Director: completely filled in by the hours after death Within 2 To the I

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Certification:

Medical

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26.Place of Death (Check only one) 25. Was case referred to medical Other, examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 V Natural Yes 2 No Pendina Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide Homicide 29a. Certifier 1

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (item 23a)

Pamela E. Southall, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

31. Date filed 6 Registrar

May 22, 2009

		1	For State Registrar	State	of Marylan		artmen rtificat			ınd M		iene <sub>eg. No.</sub> C	2009	1669	7
Phys	siciar		1. Decedent's Name (First, Middle, L	ast)							2. Date of Dear Month	Day	Year	3. Time of Death	
	edica	1	GRACE HOLMES  4a. Facility Name (If not institution, g.	ive street and n	umber)		4b. City,	Town, or	Location of	f Death	MAY	20 4c. Co	2009 ounty of Death	10:40P <sup>M</sup>	_
EXAI			214 Leslie Avenu	Je	,		Bal	timo	re Co	unty			Baltim		
Funer Direct	_		212-10-9444	Sex 1 □ M 2 💢 F	7. Age (In yrs. 91	la <i>st birthday)</i> Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day JULY I	,°1917	9. Birthp Cour Mar	place (State or Foreign htry) yland	-
ryland how	ř.		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits	_
he Mai 28a-f s			Maryland Baltimo	ore					imore	Cou		0- 0:::		1 □Yes 2 No	_
a with t		1 7	10e. Street and Number 214 Leslie Avenu	Je			10f. Zip	Code	2123	6		0	n of What Cour JSA	itry ?	
DEALKITHOFE, INIGITY ISING 21213-UUSD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, he Medical Eventher must be notified at		by runeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F	2 No		Mas Deced fYes, sped		spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	ecify Yes or No- Rican, etc.)		. Race - Americ Black, White,	etc.	_
72 hours aft "natural", or	1		3 ☑ Widowed 4 ☐ Divorced  15. Decedent's B	Ye ar or	Dates:	16a, Deced			, ,				of Business/In	ite	
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Mary d 2 shoulth and lith and lith and lith trains	ľ		19a. Informant's Name/Relationship				•	*			I Route Numbe			Code)	
re, r s 1 and f Healt item 27		1	Maria C. Smith ( 20a. Method of Disposition	(MIECE)	20b. F	Place of Dispo					ltimore	<u> </u>	tion - City or To	own, State	_
altimor rmit. Pages spartment of portant: If its	.	1	XXBurial 2 ☐ Cremation 3 I 4 ☐ Donation 5 ☐ Other (Spec			rkwood				-23-	2009	Balt	timore,	Md.	
permit. Departi	once.		21. Signature of Funeral Service Lice	ensee	/	7	assar 401 E	n Addres 3ela:	ineral ir Rd.	L Hor Bal	ne ltimore	, Md.	21236		
cate be executed when the burish-transit the burish-transit	al er	alcai Examinel	23a. Part1. Enter the disease, or corshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it are a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	each line.  2-10 eur  o (or as a consequence)  o (or as a consequence)	uence of):	dem			cardiac o	rospiratory an	031,		Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certification to the Funsa fater death certificate the theoretical Unrector. After this certificate has been signed by the attending phompietely filled in by the funeral director, page 2 should be detached for use as the complete of the funeral director.		r ilysiciali/iwed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Whe 9 □ Unknown	1 🗌 Live	utcome of pregna birth 2 Peta gnant at time of c	ıl death 3 □	Ectopic p		1			23	d. Date of deliv	ery Day Year	
es that igned b	0	yu	Part II. Other significant conditions	contributing to	death but not res	ulting in the ur	nderlying c	ause give	en in Part I.					he cause of death?	
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ician: The lav certificate has	2		OF Was soon referred to modical								autops perfor 1 🗆 Yes	sy med? 29 <mark>⊠N</mark> o	prior to co death? 1 🗆 Yes	opsy findings available impletion of cause of	
ysicia ysicia iis cert directo	Į,		25. Was case referred to medical examiner? 1 ☐ Yes 27 ♣No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 🗆 DC	Othe	vr.		(Check only or ne 5≰Resid		☐Other (Speci	fy)	
Attending Phy ar death.  ector: After this by the f.neral d	100	alloil.	27. Manner of Death  12 Natural 5 ☐ Pending 2 ☐ Accident investigation	on (Mo	e of Injury onth, Day, Year)	28b. Time of Injury	f 2	28c. Injury Work 1 □		2	28d. Describe h				
tal or Att s after de al Direct ed n by t	Continue		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Plac	ce of Injury - At ho ding, etc. <i>(Specil</i>	ome, farm, str	eet, factory	, office		2	28f. Location (S City or Tow		Number or Run	al Route Number,	
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			10/	no			1/7	00	4429	6		May	122,2	voq	
		- 1	30. Name any address of erson who	completed cal	use of death (Iter - <b>7</b> 05	n 23a) (Type, Dir tal	Draw	e, Si	nte 6	_ (	which	m, N	D 210	90	
Regi	State istrai		29b. Signature and title of certifier  30. Name an rado ess of erson who  MARIAN C., RUTTC.  31. Date filled (Month, Day, Year)  MAY 2.6 200	g Jene	Registrar's Signa	sture Sau	Kend								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 Johanna Patricia Hagedorn 20, 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Burn Flen Balt. Wash. Medical Center Ann-e ~ male If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Oct. 3, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1946 Min Months Days Hours 1 □ M 2 🔀 F 62 220-50-1781 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 United States 8011 Covington Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ∏Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Anne Arunel County Elementary/Secondary (0-12) College (1-4or 5+) Payroll Worker Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie W. Wink Frederick A. Sipes, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl W. Hagedorn, Jr. / Husband 8011 Covington Ave., Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 27, 20c. Location - City or Town, State May 27 2009 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 4 ☐ Donation (5 ☐ Other (Specify) Elkridge, Maryland 21. Signature of Fluntia Service 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, 0 MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 116555V 153 m disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year 5 Other (specify) 2° No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 X Yes 2 2 26. Place of Death (Check only one) 2 No 25. Was case referred to medical examiner' Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient

**Physician** /Medical Examiner

attending physician

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24 hours after death Funeral Director:

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**Physician** 

/Medical

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Eventinar must be motified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mode once.

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

been signed by ti should be detach

Examiner Physician/Medical 2 Completed funeral director, Be Certification: To

Medical

in the past 12 months?
1 Yes 2 No 9 Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No 27. Manner of Death 12 Natural 5 ☐ Pending 2 Accident investigation 3 Suicide 6 ☐ Could not be determined 4 Homicide

28a. Date of Injury 28b. Time of (Month, Day, Year)

28c. Injury at Work? 1 □Yes 2 □ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

ts Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and tible of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TS 0

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month; Day; Year,

rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician ster /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner st birthday) Sex 1X M 2□ F Birthplace (State or Foreign Country) 7. Age (In y 8. Date of Birth (Month, Day, **Funeral** 250-42-9664 9 South Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: þ Specify: aryland 21215-003 3 ☐ Widowed 4 ☐ Divorced Year or Dates: ac n and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Pfint) Department of Health a Important: If item 27 is any Injury or other trauonce. SMAIIWOOD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) sdowne, Md Dn 22. Name and Address of Facility 21. Signature of Funeral Service Licenses W. North Part . Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Bone Metasasis Oyears **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). The law requires that the death certificate be executed and the burial-trai resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. detached 9 Unknown is been signed by th 2 should be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by event 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 C Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe this certificate 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \) 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) OSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation neral Director: A 1 □Yes 2 □No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide To the Funeral I within 24 hours Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. MSCHOW 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 2009 death (Item 23a) (Type, Print) Baltimore Suite 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle 3. Time of Death Last) 2. Date of Death **Physician** Month Mai 1834 2009 eeter arold /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner anda 4102Dita Thiles 101 Birthplace (State or Foreign Country) Number 7. Age (In yrs. last birthday) Funeral 7 / 11 / 1931 Hours 1**X** M 2□ F Month Days 317-30-9930 77 OH Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show Department of Health and Mental Hygiene. Important: if item 271s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinar must be rediffed a goog. Director 1 ☐ Yes 2 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3711 Collier Rd. 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates:1951-54 Specify. þ Specify: White 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United Optical Optician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Helen Roeger David Heeter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Hillcrest St., Hampstead, MD 21074 Tom Heeter/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/2<sup>0</sup>872009 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. Owings Mills, MD eral Service Licensee 22. Name and Address of Facility. Burrier-Queen Funeral Home & Crematory, P.A 1212 W. Old Liberty Rd., Winfield, MD 21784 Approximate Interval Between Onset and Death art 1 Enter the disease, or complication show, or heart failure. List only one can that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Imm at ate Cause (Final **Physician** 10 days disease or condition resulting in death) ESDINATORI /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Ulmanan Due to (or as a consequence ) The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transi Exami leumoni a resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 3 Ectopic pregnancy Month Day Year P.O. 5 ☐ Other (specify) ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Division of Vital spital or Attending Physician: Theoris after death.
Ineral Director: After this certificate y filled in by the funeral director, par 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was c e referred to medical examiner: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 DNetwal 5 Pending investigation 2 🗀 No 1 ☐ Yes 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier May 23, 2009 H0068505 rson who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month,

andall

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Funeral Director

		For State Registrar		State o	f Marylan	-	rtment of He tificate of D		·	giene (	009	16701
		Decedent's Name (First)	t, Middle, La	ist)					2. Date of De Month		Year	3. Time of Death
Physicia Medic		Bland	che	D.	Hansor	1			May	21	2009	8:51a M
Examin		4a. Facility Name (If not in					4b. City, Town, or L	ocation of Death	1		nty of Death	
		Greater Ba				iter	Towson	If Under 24 Hrs	La Data (Dia		ltimor	
uneral irector		5. Social Security Number 218-12-7008		Sex 1 □ M 2 □ <b>X</b> F	7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	ıy, Year)	Mary	place (State or Foreign ntry) / land
A		Usual Residence of Deced	ient County		10c. Cit	y, Town or Loc	eation				1	I0d. Inside City Limits
f sho	Ď		altimo	ore	В	Baltimo	re County			1 ☐ Yes 2 🔯 No		
28a	Director	10e. Street and Number					10f. Zip Code			10g. Citizen	of What Cour	ntry?
3a o	al D	8100 Dales	ford	Road			21234			U.S.	.Α.	
ems 2	Funeral	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U.	S. 13. V	Vas Decedent of His Yes, specify Cuban,	panic Origin? (S Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. F	Race - Americ	
or it	by Fu	1 Never Married 2		1 X Yes If Yes, Gi	2 □ No 194 ve 104	- C+	□Yes 2 No	Specify:			olfu	nite
tural'		3 X Widowed 4 □ Di	ecedent's E	Year or D	ates:		ent's Usual Occupat	ion		16b. Kind of	f Business/In	
n "na Medic	plet	(Specify only Elementary/Secondary (	y highest gr	ade completed) College (1	4or 5 . )	(Give	kind of work done du OO NOT use retired)		king			
ar tha	Completed	Liementary/Secondary (	(0-12)	+4	1-401 5+)	Nur	se			Heal	th Car	e
d other	Be (	17. Father's Name (First, I		Ť.			1		ne (First, Middle	, Maiden Surr	name)	
arke	2			orfler					Morgan			
7 Isrr traum		19a. Informant's Name/Re			or		g Address (Street ar Box 397					o Code)
tem 2		Terry Phill 20a. Method of Disposition		Daugni			sition (Name of patory or other place)		Date		on - City or To	own, State
Depointment of from an working raybene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examinar must be notified at once.		1 🔀 Burial 2 ☐ Cren 4 ☐ Donation 5 ☐ O	nation 3 D other (Speci	ify)	State Du Men	laney v lorial	Gardens	05-2	26-2009			Maryland
Impor any in		21. Signature of Funeral S	Service Lice	nsee ()	ldu		. Name and Address Ruck Tows 1050 York	on Funer	ral Home	, Inc.	14	
		23a. Part 1. Enter the dise shock, or heart failur	ease, or con	nplications that o	aused the deaf	h. Do not ente						Approximate Interval Between
sician		Immediate Cause (Final disease or condition		_ a.	PEN	ヘビル・	TIA					Onset and Death
ledical aminer		resulting in death)	•	Due to	(or as a conseq	uence of):						
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ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	~		(							
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attend for us	Physician/M	23b. Was decedent pregn in the past 12 months		1 🔲 Live	tcome of pregna birth 2 D Feta	al death 3 □	Ectopic pregnancy			23d.	Date of deliv Month	very Day Year
y the	ysic	1 □ Yes 2 □ ★10 9 □ Unknown		9 ☐ Unkr	nant at time of o	ieam 5L	Other (specify)					
ned by	by Ph	Part II. Other significant of	onditions	contributing to de	eath but not res	ulting in the ur	derlying cause giver	in Part I.	23e. Did 1	tobacco use c	ontribute to t	the cause of death?
en sig uld be		SEP	515						1 🗆	Yes 2□N	o 3□ Pro	bably 4 hknown
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ate ha	E									ormed? 2 ☑ No	death?	2 □No
ertific ictor,	Be	25. Was case referred to r examiner?	medical						ath (Check only	one)		
this c al dire	၉	1 Yes 2 No			Inpatient 2 3			4 L Nursing F	forme 5 ☐ Resi			ify)
After	ion		Pending		of Injury th, Day, Year)	28b. Time of Injury	Work?	at es 2 ⊡No	28d. Describe	how injury oc	curred	
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I Dire	Certification:	4 ☐ Homicide	determined		ing, etc. (Specia				City or To			
To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C			miner: On the b			n occurred at the time vestigation, in my opi					
To the	Me	29b. Signature and title of	sertifier	1//			29c. License	number		29d. Date si	gned (Month,	, Day, Year)
			201	9	M.	p.	P57	122		MAY	21	2009
\ /		30. Name and address of	person who	completed caus	se of death (Iter	n 23a) (Type,						
. 1		LEUNARD R	ICHA	20502	M-P 15	38 G	REENE 71	LE E ROA	n#300	PHRESVI	LLE MI	21208
Sta Registr		30. Name and address of LCVNA CO R 31. Date filed (Month, Day	vor	2009 32. F	terstrar's Signa	aure A	backs					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** May 22. 2009 7:35 Α Hinkle Frances Agnes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooklyn Park Anne Arundel Genesis Healthcare If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y October 5, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Months Davs 1 □ M 2 1 F 1916 Maryland 92 Director 215-52-1352 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show ed other than "natural", or Items 23a or 28a-f show event, the Wedley Expression or must be notified at 1 X Yes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 U.S.A. 510 East Clement Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Own Home Homemaker h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 is marked oth any injury or other traumatic event Be Kellv Hinkle Margaret Andrew ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Hopkins Street Baltimore, Maryland 21225 Edgar L. Collison (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/27/09 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 237 Fast Patapsco Avenue Baltimore, Maryland 21225 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocked heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** erchro 7 de /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and Due to (or as a consequence of) Box 68760. physician the death certificate be Physician/Medical the as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Po in the past 12 months? Month Day Year 5 ☐ Other (specify) 0 25 detached 9 Unknown 9 Unknow signed by σ. The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. <u>}</u> pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐ Yes ANO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1∐ Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 ☐ Accident 5 ☐ Pending To the Hospina within 24 hours after death.
To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) With Port Rd 7566 31. Date filed (Month, Day, egistrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 12:55P<sup>M</sup> 14, 2009 Warner Higgs May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dove House Hospice Westminster <u>Carroll</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, You Feb. 13, 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** Year 1**℃** M 2 🗆 F Yrs 217-16-7818 88 1921 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 4 Seiler Court 21136 U.S.A. Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐Yes 2 No þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reeder Benjamin Higgs Cora ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21136 Harriett K. Higgs Seiler Court Reisterstown, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation Ser 5/15/09 Hampstead, Maryland 21. Sign tur Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home tano 12 salused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. P. rt1. Enter the disease, or complications that nock, or heart failure. List only one cause on Immediate Cause (Final isease or condition resulting in death) **Physician** /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 2 □No □Yes detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 3 Probably 4 Unknown Completed been : Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No 2 [ 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 [ Other (Specify Certification: To 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Prineral Director: completely filled in by the 6 ☐ Could not be 3 Suicide of Jury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 16 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person no completed cause of death (Item 23a) (Type, Print)

State Registrar Registrar's

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State of Mar	yland / Departme	ent of Health	and Menta	l Hygiene U	U

			For Stete Registrar	State of Maryland		irtment of H tificate of L			ene UUJ . No.	16/04		
	Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death			
	Physici		Dorothy L. Hammon	nd				Month May 19		11:00 P <sup>M</sup>		
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea			
	- Admin	-	707 Maiden Choic	e Lane #9111		Catons	ville		Baltimo	re		
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Bi	rthplace (State or Foreign		
	Director		212-01-1370	M 213kF 96	Yrs.	Months Days		Nov. 5,	912 Ma	ryland		
-	ס		Usual Residence of Decedent									
	ylan how		10a. State 10b. County	10c. City	, To <b>wn</b> or Lo	cation				10d. Inside City Limits		
	Ma S-f-	ţ	Maryland Baltimon	ce Ca	tonsvi	.11e				1 ☐ Yes 2 📆 No		
	7.28 1.28	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What C	ountry?		
	138 c		707 Maiden Choice	Lane #9111		21228		τ	JSA			
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am Black, Wh			
Q	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of the Tris marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Meulcal Eventure in mail be notified at once.	교	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ½ No If Yes, Give		Yes 25 No	Specify:	racan, oto.,	Specify:	White		
3	ours	l by	3 ₩ Widowed 4 □ Divorced	Year or Dates:			орослу.		Ореспу.	WILLE		
ה	72 h natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	lent's Usual Occupa kind of work done o	lurina most of work	ing 16	b. Kind of Busines	s/Industry		
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7	ygien /gien er th	ပ္ပ		4	Supe	rvisor			Life In	surance		
	al Hy d oth	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	iden Sumame)			
Maryiand	Ment Ment arked	2	Andrew F. Ludwi	3			Amanda	Hahn				
a	and and is ma		19a. Informant's Name/Relationship (T)					al Route Number, (				
Σ.	and and alth		Julia H. Latta	Niece	612 1	ark Ridge		Mt. Airy				
e e	of He of He roth		20a. Method of Disposition 1 ☼Burial 2 ☐ Cremation 3 ☐ F		lace of Dispo emetery, cren	sition (Name of natory or other plac	9)		c. Location - City o			
Ĕ	Pagent ant: I sury o		'4 Donation 5 ☐ Other (Specify)			rk Cemete				, Maryland		
altimore,	parting porte		21. Jign. ture of Funeral Service Licens	10	/ 22	Name and Addres	s of Facility Ste	rling Asl	ton Schw	ab Witzke		
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			23a. Part. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	nysician		Immediate Cause (Final	V Cause on each line.	nec	mon	1'9			Onset and Death		
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):									
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DIVISION OF VITAL RECORDS,	Ing P	Certification:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 Autural 5 Pending (Month, Day Year) Injury Work?						28d. Describe how injury occurred			
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2	To the Hospitel or Attending Physicien: The law within 24 burus after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2											
	To the Hospitel or within 24 hours at To the Funerel D completely fitted in	edical	(Check only 2 Medicel Exam:	eiclan: To the best of my kno iner: On the basis of examina								
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	To To	Σ	29b. Signature and title of certifier	/ 12 =		29c. Licens	number -	290	d. Date signed (Mo	iur, Day, rear)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Karole L. Horner 20 2009 6:30 ΑM May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis HealthCare -Talbot The Pines Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 5, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Months Days 1 □ M 2 🕅 F 1941 Maryland 217-34-8816 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinational be recitled at once. 1 ☐ Yes 2 ☑ No Director Maryland | Dorchester Easton 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 21664 3634 Green Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married White Maryland 21215-0036 1 ☐Yes 2X No Specify ģ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gilda Schwab George N. Wolfe ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3634 Green Point Road; Secretary, MD 21664 Husband Jack Horner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, Maryland Lorraine Park Cem. 5/28/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schu Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, Schwab Witzke 21. Signature of Funeral Service Licenses W01020 tedema MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HERA3 **Physician** disease or condition resulting in death) /Medical Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 No Month 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce

State Registrar

MICHAEL 31. Date filed (Month, Day,

Horner

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Baltimore. Karol

P.O. Box 68760.

Division of Vital Records.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROWLE

MAY 26 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registrar 6/06 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 10:38 PM MAY Raymond Roy Jordan 16 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A HOSPITAL BALTIMORE ST AGNES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Hours 1**X** M 2□ F Days 62 Maryland 07/06/1946 217 46 1959 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 K No Anne Arundel Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21225 226 Southerly Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Widowed 4 Divorced White Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fire Department <u>6t</u>h Firefighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond M. Jordan Annie Warner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Michele Jordan / Daughter 226 Southerly Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/22/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Moreland Park 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licen Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the 4th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final HOURS ASPIRATION disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown WITH GASTROINTESTINAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident

Examiner Examiner The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-trar Physician/Medical Completed by has this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p Be Certification: To

Vital

Division of

JORDAN

Physician

Examiner

Director

Funeral

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland

3

item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

tal Hygiene.

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of Health

permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.

**Physician** 

/Medical

/Medical

GASTRIC ULCER

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

3 Suicide

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Evelyn Gathelina

determined

29c. License number

29d. Date signed (Month, Day, Year) 2009 16

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE MD 900 5 CATON AUE EVELYN GATHEUTA

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 26

			For State Registrar	State of Mar	ryland		artment o r <i>tificate</i> (			and Me	-	gien Reg. N	- Z U U	9	167	07
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altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantion of the frontified at once.		21. Signature of Funeral Service Lice	- 1	Cit	22	Nome and A	ddroop of	Engilit							
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	Registra	ar	31. Date filed (Month, Pay, Year) MAY 26 20(	19 augus	1	ba	Kel									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year 615 PM **Physician** JOHN SON BEATRICE Hay 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown North WEST HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 😾 F Months Days Hours Min Director 212-30-0582 7 g 76/1931 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Madical Examiner must be notified at Director 1 ☐ Yes 2 XNo MD Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the A Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural". Or its any injury or other traumatic event Reisterstown 10e. Street and Number 10g. Citizen of What Country? 228 Persimmon Circle 21136 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 ∐Yes 2 X No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 □Yes 2\ONo Specify Specify: Black þ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic <del>11 th</del> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alphonso Cooper Beatrice Bush ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Persimmon Circle Reisterstown, MD 21136 Denise Johnson/daughter 228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/27/2009 Woodlawn, MD 21. Signature of Funeral S vice Licens 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215 23a. Part 1. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immo late Cause (Final **Physician** Sepsis disease or condition resulting in death) Medical / Due to (or as a consequence of): Examiner PMEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): law requires that the death certificate be executed burial-transit Exami Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical the as for use a IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death ‡ ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? has certificate 2 ANO of Vital 1 🗆 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 HO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) MAY 26 2009

29b. Signature and title of certifier

460121124

Old Court KOFFOUNI 5401 32. Registrar's Signature

Colera

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D65843

29d. Date signed (Month, Day, Year)

Road, Randallstown, MD 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 6:04 P JOHNSON 1AS 200 ENNETH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GENERAL TIMORE Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director ice of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits works ! items 23a or 28a-f shov ner must be notified at 1 Yes 2 No Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status Black, White, etc. ral", or iten Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced "natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Department of Health and Mental Hygio Important: If Item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Sister) 0 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

S MINVEX Immediate Cause (Final disease or condition resulting in death) Physician XSANGUINATION /Medical Examiner GASTROINTESTINAL BLEED ISMINUTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit CIRRHOSIS Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 4 Unknown 1 TYes 2 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 1 Natural 2 □ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Yes 2 No within 24 hours at er death.

To the Funeral Director:

completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name

31. Date filed (Month)

AVENUE,

BAITIMORE MO 21201

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03957 Lee Ronel Johnson State of Maryland / Department of Health and Mental Hygiene 2009 1671 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Date of Death 3. Time of Death Physician/ Month Day May 18, 2009 Year 1547 hrs Lee Ronel Johnson Jr. **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital Raltimore Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) MD Months Hours Davs Director 218-25-5250 19 10/03/1989 1 X M 2 Usual Residence of Deceden 10d Inside City Limits 10c. City, Town or Location 'n 10a. State 10b. County Baltimore 1 X Yes 2 No MD 28a-f show with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2037 N. Braddish Ave. Apt. 2 USA 21216 0 238 Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or Nodeath v If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Black f Yes, Give Year Yes 2 X No specify. Specify hours after Divorced Widowed ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 Home Improvement Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than 's rother traumatic event, the Medical Baltimore, MD 21215-0036 Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Ronel Johnson Sr. Chervl Lavern Byrd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 2037 N. Braddish Ave., Apt. 2, Baltimore, MD 21216 Cheryl L. Walker / Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State W. Arundel Crematory 05/26/2009 Odenton, MD permit. Pages
Department of
Important: 1 Donation 5 Other Specify: 9 22. Name and Address of Facility Rendon-Bailey Funeral Home, PA 21. Signature of Funeral Service Licensee 8 142 M01452 Ma 2818 E. Baltimore St., Baltimore, MD 21224 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a Gunshot Wound of Head with complications Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) executed and sician/Medical physician a the burial -UNPENDED AMENDED certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death attending past 12 months? Pregnant at time of death 5 requires that the death Yes 2 No 9 Unknown q Unknown Phy 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? page ✓ Yes 2 1 V Yes 2 No certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 10 1 🗸 Yes 28a. Date of Injury (Mouth, Day, Year Sep 27, 2008 28d Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot 1045 hrs Natural Yes 2 V No 5 death. Director: the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 1900 Block Frederick Avenue, Baltimore, MD determined To the Funeral (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier May 19, 2009 O.C.M.E a 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner MAY 26 2009 32. Registrar's Signature 31. Date filed (Month, State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2009 RUTH EDNA KANDEL 16:27P<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll County Carroll Dove House If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 26°1922 Months Days Hours 1 ☐ M 2 🖫 F Baltimore City, Md. 217 22 1305 87 Director January Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No New Windsor Funeral Director Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2314 Bowersox Road 21776 USA items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 【XXo Specify. Completed by Specify. 3 X Widowed 4 ☐ Divorced "natural", White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, In a Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (A<sup>4</sup>or 5+) Housewife Housekeeping-Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catharine Borne Lemke John Asher Sealover ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2314 Bowersox Road New Windsor, Md. 21776 Catharine M. Chenoweth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery May 27 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the discree, or complications that caused the and the Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** 154 DIG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 ⊡No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Box 68760, Division of Vital Records, P.O.

Hospital or Attending Physician: The law requires that the death certificate be executed Director: / hours after within 24 hours a

To the Funeral

Certification: To 4 Homicide Medical

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

5 Pending investigation

6 Could not be determined

26 2009

28a. Date of Injury

(Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

29c. License number

29d. Date signed (Month, Day, Year)

Westminster MD ZUS 7

6 ☐ Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month. Day, Year)

32. Registrar's Signature

State Registrar

To the

State of Maryland / Department of Health and Mental Hygiene 2 0 9 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5/22/2009 7:45 AM Ethel M. Keller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/2/1921 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 ☐ M 2 🛣 F MD 87 Director 216-14-3663 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Midcal Examine more once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 XNo Director Randallstown Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21133 3323 Offut Rd. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Specify: White 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Balt. Co. Public Schools 12 Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virgiele Duffmeyer William Garfield Dugan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2503 Karen Way, Westminster, MD 21157 Jeannie Lawson/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/8/2009 Granite, MD Granite Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Burrier Owelfr Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** DAYS Strake disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): law requires that the death certificate be executed as the burial-trans Exami Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending IF FEMALE: use a 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year for in the past 12 p onths? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? 1 ☐ Yes 2 No The 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral ( 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TONSIN NO 6701 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death **Physician** РМ 4:15 Kripa Shanker Kashyap 2009 /Medical May 4b. City, Town, or Location of Death 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Ye Jan. 18, If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min 1**X** M 2□ F 386-54-6940 1942 Jaunpur India Director 67 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Iftem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be netitied at 1 ☐ Yes 2 X No Director MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 711 Milldam Road 21286 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 XNo Maryland 21215-0036 Specify If Yes, Give Year or Dates Specify: Asian Indian þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Psychiatry Phychiatrist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Chandra Bali Singh Jayanti Devi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD 21286 711 Milldam Road Sheela Kashyap/Wife permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 25, 1 Burial 2 Cremation May 25 2009 3 Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Oth (Specify) Glen Burnie, MD 21. Signature of Funeral Serv Lemmon Funeral Home of Dulaney Valley, Bryan W. Clary 10 W. Padonia Road Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** Grown of the to (or as a consequence of): gram disease or condition resulting in death) /Medical Examiner leutropenia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed ara e burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 \( \Bigcap \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Gusne Suite 550

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

26 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2009 Month **Physician** 3:38  $P^{M}$ May Anna Mae Krause /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson <u>Baltimore</u> Gilchrist 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Months Davs 1 □ M 2 💢 F Director 30, 1917 Maryland 214-03-2620 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination to all the Analysis 1 ☐ Yes 2 📉 🖔 Director Maryland Carrol1 Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4466-622 Woodsman Drive 21074 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2X No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: <u>ک</u> 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Nadolnv Josephine Drankiwiecz Adam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4466-622 Woodsman Drive Hampstead, Maryland 21074 Susan E. Reichard Daughter 20b. Place of Disposition (Name of commetery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium 5-29-2009 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet and Death d Em Immediate Cause (Final den Physician disease or condition resulting in death) /Medical as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transi Due to (or as a conse ruence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) signed by the a 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 9 Hospital or Attending Physician: The I 24 hours after death.
9 Funeral Director: After this certificate ha perform 2 X No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 20 No Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

			State	of Maryland /		rtment of H			21111	9 16715
			Registrar		Cer	uncate of L	Jealii	2. Date of Deat	leg. No. Co	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)	KENYO	NI			Month	Day Yea	
	/Medic		ROLAND J		7	4h City Town or	Location of Death	May	17 2009 4c. County of De	
	Examin	er	4a. Facility Name (If not institution, give street and						Carr	
			Transitions Health Ca 5. Social Security Number 6. Sex	are 7. Age (In yrs. last I	birthday)	Sykesv If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. E	Sirthplace (State or Foreign
и	Funeral Director		220-20-5120 1X M 2		Yrs.	Months Days	Hours Min.	(Month, Day March 2	1,1929	MD
			Usual Residence of Decedent							Total Control
	rylan how	_	10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	e Ma 3a-f s	cto	MD Carroll	We	stmi	nster				
	or 28	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What	Country?
	ath w	Funeral I	1215 Klee Mill Road			211			USA	mariana Indian
	er de	nue	Armed	Decedent Ever in U.S. d Forces?	13. \	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	Black, Wi	nerican Indian, nite, etc.
36	s aft	by F	If Yes	es 2 □ No , Give or Dates:	1	□Yes 2\\\X\\No	Specify:		Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygene. other than "natural", or items 23a or 28a-f show ent, the Modeal Evenine must be rediffed at	ed	15. Decedent's Education		Sa. Deced	lent's Usual Occup	ation		16b. Kind of Busines	
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212	giene giene rr tha	ĕ	8	ge (1-40) 5+)		Truck Dri	ver		Transpo	rtation
g	al Hy al Hy othe	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surname)	
<u> a</u>	should be f and Mental s marked o sumatic eve	၉	John Henry Kenyon				Adel		ossman	
a	2 sho n and is ma rauma	3	19a. Informant's Name/Relationship (Type. Print)						er, City or Town, State	
Baltimore, Maryland	1 and 2 Health em 27 i	100	Pauline M. Kenyon					estminst Date	zer, MD 21	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modeal Externine must be refilled at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal fi	cama	etery, cren	sition (Name of natory or other plac	e)		·	
Ë.	t. Par tmen tant: jury	19	4 □ Donation 5 □ Other (Specify)	Wood	-	Cemetery		0/09	-	, Maryland
gal	Depar Mpor Iny Ir	ļ. [	21. Sign tu e Funeral pervice Licensee	Serken		. Name and Addre	·		Reisters	
	40 <b>2</b> 6 6		23a. Part 1. Enter/the disease, or complications the	by acused the death. D			eral Home		terstown,	Approximate
		3 1	shock, or heart failure. List only one cause	on each line.						Interval Between
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Box	seath certific attending p	an/l	23b. Was decedent pregnant	s, outcome of pregnancy Live birth 2☐ Fetal dea	ath 3∐	Ectopic pregnanc	ey .		23d, Date of Month	delivery Day Ye <i>a</i> r
C.	the a	Physician/Me	4 DV: 2 DN: 4 U	Pregnant at time of deatl Unknown	h 5L	Other (specify) _				
P.O.	hat the	문	Part II. Other significant conditions contributing	to death but not resulting	a in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
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Re	ne law e has ge 2 s	ם						autop	osy prior rmed? deat	to completion of cause of h?
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Division of Vital Records,	r Atte er de recto by th	ertification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. F	Place of Injury - At home building, etc. (Specify)	, farm, sti	eet, factory, office	1/2	28f. Location (S City or Tov		r Rural Route Number,
۵	italo Irs aft ral Di	Cer								
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Medical	29a. Certifier (Check only one)  1 Certifying Physician: T  2 Medical Examiner: On and	o the best of my knowle the basis of examination manner stated.	dge, deat and/or ir	h occurred at the to vestigation, in my	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	mariner states.		29c. Licens	se number		29d. Date signed (M	lonth, Day, Year)
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			30. Name and address of person who completed	cause of death (Item 23	Ba) (Type	Print)	0	1/2/		MD
\			TARIO MAH	1 GOON	9, K	idye!	1600d	rejth	unster	21157
	Sta		31. Date filed (Month, Day, Year)	cause of death (Item 23	1	ake				ind
	Regist	rar	MAY 25 2009	comment.	11					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2:00 PM orraine Ma 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Isa imore UNSING If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 25,1931 Birthplace (State or Foreign Country) Age (In yrs. ast birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 🛭 F 218-28-6091 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimroe Catonsville 10g. Citizen of What Country? 10f. Zin Code 10e Street and Number 21228 USA 8 Trotters Ridge Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No White Specify: <u>ک</u> 3 X Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d other than "natu 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 7 Is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Schoeberlein Anna Hill ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any injury or other troope. Trotters Ridge Court; Catonsville, MD 21228 Daughter Mary Carol Kulacki 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 6/2/2009 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) been signed by the should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 15W empol 2 X No 3 Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 0 certificate has birector, page 2 sl autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this ours after death.

neral Director: After this filled in by the funeral d 27. Marnner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Baltimore 3320 ) enson 31. Date filed (Morth, Day, Year, State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene me, 2391,05/26/09dhb Reg. No. Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Elizabeth Laws Mary 23 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Union Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 3-20-1927 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 82 S.C. Director 220-20-8903 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Examiner must be notified at XXYes 2 □ No Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21211 3838 Roland Avenue Apt 1001 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 XNo Black If Yes, Give Year or Dates Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ment of Health and Mental Hygiene.

nt: If item 27 is marked other than "n:
y or other traumatic event" Dept of Social College (1-4or 5+) Elementary/Secondary (0-12) Case Worker Services 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Cook Vernon Laws 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 Brendon Avenue Balto, MD 21213 Eloise Laws-Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Maurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or 5-16-2009 Laurel, MD MD National Mem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H Mla North Avenue Balto, MD 22102 1101 E. ans Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HU WILMSTER disease or condition resulting in death) /Medical Due or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown á s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate has page 2 director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) deterpained 4 Homicide 5 To the Hospital within 24 hours a To the Funeral L the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner-stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler M 15 completed cause of death (Item 23a) (Type, Print) 30. Name and address of p

State Registrar VIJAY S 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician ALLEN LIVE SAY 2009 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE LUTHERVILLE COLLEGE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FES 2 193 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F 225 44 Director 6075 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ns 23a or 28a-f show must be notified at 1 Yes 2 □ No Director BALTIMORE MA WINDSOR MILL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA ROAN 21244 Funeral I 7720 FAIR BROOK items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗷 No Specify: by WHITE 3 ☐ Widowed 4 X Divorced "natural", 12 Shound Demonstrate that and Mental Hygiene, 17 is marked other than "natural the medical E. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) TRI-COUNTY Elementary/Secondary (0-12) College (1-4or 5+) REPAIR TELEVISION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANDIE COLLINSWOR LIVE SAY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau once. MENGES TANEYTOWN, MO 21787 Rd MILL 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/28/2009 WINFIECH, MU 22. Name and Address of Facility JN 2 mB nw FH & mov G-21. Signature of Funeral Service Licensee SYKESVILLE Rel ELDEISBURG MO 21784 23a. Part J. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician a P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 1 Tes P Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury a Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 🗌 Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ethla

State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** Harriett Elizabeth Layton 4:30 May 2009 Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3140 Florence Road Woodbine Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | Feb. 24, 1912 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F 217-58-4740 Maryland 97 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once. 10b. County 1 ∐Yes 2 ∏ No Director Woodbine Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 3140 Florence Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2XXXNo Specify Specify: White Completed by 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Gertrude Gilliss George D. Moyer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3140 B Florence Road Woodbine, MD 21797 Mr. Carl Layton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jennings Chapel Cem. May 29, 2009 Woodbine, MD 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784
Approximate e of Funeral Service Lic Approximate Interval Between Onset and Death art . Enter the disease, or complication sho x, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Immediate Cause (Final disease) r condition resulting in death) erebrovascular acciden **Physician** 24 hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to find editionate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Que to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. ed by the 9 I Inknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ 0 24a. Was an has 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and 29d. Date, signed (Month, Day, Year) titlé of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Main Street Suite 202 M+ Airy M 50Z McIntyre 31. Date filed (Month, Day, Year) / Registrar's Signature State MAY 26 2009 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 9:50 AM 21, 2009 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Baltimore Gwynn Oak Augsburg Lutheran Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F March 24, 82 1927 Maryland Director 220-20-1335 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State If item 27 is marked other than "natural", or items 23a or 28a-f shore or other traumatic event, the Wedical Examinational be notified at 1 ☐ Yes 2 No Funeral Director Gwynn Oak Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6811 Campfield Road 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2K Married 1 □Yes 2 📉 No Specify: Specify: White ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Government 4 Highway Planner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John David Lentz Helen Mae Yingling ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 11067 Scotts Landing Road Laurel, MD 20723 Daniel G. Lentz/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial
Park Cemetery 20c. Location - City or Town, State 20a. Method of Disposition May 27, 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Laurel 4 ☐ Donation 5 ☐ Other (Specify) Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Fune Inc. J. Flagle or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is only one cause on each line. Approximate Interval Between Onset and Death Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final Physician ears resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last red by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 sl autopsy 2 No 2 🗆 No 1 □Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1-ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 21,2009 30. Name and address of person w completed cause of death (Item 23a) (Type, Print) MD Main 51, 25 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

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Physician
/Medica
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**Funeral** Director

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarinar must be notified at once. Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Funeral		5. Social Security Number		7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9	Birthplace (State or Foreign     Country)
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Marylan f show	lor	10a. State 10b. County  MD BALTI	MORF	10c. C	ity, Town or Lo BALTIN					10d. Inside City Limits 1 ∐Yes 2 ☑ No
ith the or 28a-	Director	10e. Street and Number			DALIT	10f. Zip Code		1	0g. Citizen of Wh	at Country?
eath w	Funeral	2331 OLD COURT	ROAD #30		10 12 1	2120		posity Voc ex No	USA	Ainon tration
us a	ğ	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li><li>3 ☒ Widowed 4 ☐ Divorced</li></ul>	Armed For	ces? 2		was becedent of F f Yes, specify Cuba I □Yes 2 ሺ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	14. Hace - Black, Specify:	American Indian, White, etc. WHITE
n 72 hc	letec	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usual Occup	ation during most of work d)	ing	16b. Kind of Busin	ness/Industry
ZIZI ZIZI d within giene. er than ", tre Me.	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		RESIDENT			LEGUM D	ISTRIBUTION
be fill tal H d oth d oth	To Be (	17. Father's Name (First, Middle, La ABE		GUM			18. Mother's Name		CR	AMER
and 2 she ealth and n 27 is m		19a. Informant's Name/Relationshi STEVEN LEGUM			1		and Number or Run KS CIRCLE			
Dallimore, permit. Pages 1 and Der artment of Heat Important: if item 2 any injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b.	Place of Dispo	sition <i>(Name of</i> natory or other place HEBREW	ce)	Date :	20c. Location - Ci	ty or Town, State
Dallimo		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		DA		. Name and Addre		2/2009   SOL LEVIN		RSTOWN, MD ROS., INC.
B B B B B		Roled 1	du		2		STERSTOWN	ROAD -	PIKESVII	LLE, MD 21208
Physician	i	23a. Part 1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aA	ich line.		er the mode of dyir		or respiratory arre	est,	Approximate Interval Between Onset and Death
/Medical Examiner			Due to (c	or as a consec		PLINOPATE	<b>-</b>			
uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c	or as a consec			1			
be executed ician and burial-transit	cal Exa	resulting in death) Last	c Due to (c	or as a conseq	quence of):					
g physi		^	d							
Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and itely filled in by the funeral director, page 2 should be detached for use as the burial-transit	nysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 🗖 Feta ant at time of	aldeath 3⊑	Ectopic pregnanc	у		23d. Date o	•
ires that the de signed by the a	oy Pu	Part II. Other significant condition	s contributing to dea	ath but not res	ulting in the ur	derlying cause give	en in Part I.	23e. Did tob	pacco use contribu	ute to the cause of death?
w require the should be should be								1 □ Ye	s 2 No 3	Probably 4 Unknown
Physician: The law this certificate has be real director, page 2 si	Compiered							24a. Was ar autops perforn 1 □ Yes 2	y prid ned? dea	re autopsy findings available or to completion of cause of ath?  Yes 2 □ No
ysicia ysicia is certi directo	0 00	25. Was case referred to medical examiner? 1 ☐ Yes 2 【No	Hospital:	natient 2 🗆	ER/Outpatien	t 3 DOA Oth	26. Place of Death	n <i>(Check only one</i> me 5 ☐ Reside	CLA	ASON S LIOSPICT
ding Phi h. After thi funeral		27. Manner of Death  ↑ Natural 5 ☐ Pending	28a. Date of (Month		28b. Time of Injury	28c. Injur Work	y at		w injury occurred	(эреспу)
To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	cer unication:	2 ☐ Accident investigal 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place of	of Injury - At ho g, etc. (Specia	ome, farm, stre	M 1 □	Yes 2 □No	28f. Location (St. City or Town	reet and Number , State)	or Rural Route Number,
Hospita 24 hours Funeral stely fille	enical	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the bacaminer: On the bacaminer	sis of examina	owledge, death ation and/or inv	occurred at the tir	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and manr ate and place, and	ner as stated. d due to the cause(s)
To the within 2 To the comple	ME.	29b. Signature and title of certifier	2			29c. Licens				Month, Day, Year)
	1	NU Nelly	Sutin	of death ()	- 02a\ /T	H	45931		Mayz	1 2009
		la Doblac	BWW	1 Z	35 S	nHli Are	nie Seu	le 203	Balton	one MD
State Registrar		31. Date filed (Month, Day, Year) MAY 2 2 2	009 Jen	gistrar's Signa	J. Apa	ميكتر				one MD

DHMH 17 Rev 1/2001

			For State Registrar		State of	Marylan		artment o			and M	lental Hy	/gien	ZUU	9	6723
	Physici: /Medic		1. Decedent's Name (First, I		LE	.VY						2. Date of D Month MAY	19	2009	r	Time of Death 5:50P M
7	Examin	er	4a. Facility Name (If not inst.  EMERITUS OF  5. Social Security Number	PIKE	SVILLE	ber) 7. Age (In yrs.	last birthday)	4b. Cify, Tov PIKES\ If Under 1 Y	/ILI			8. Date of B	E	SALTIMO	RE	(State or Foreign
	Funeral Director		128-16-1013 Usual Residence of Deceder	nt	<b>)</b> (☐ M 2 ☐ F	83	Yrs.		ays	Hours	Min.	8. Date of B (Month, D	1925 1925	NE	Country) WYOF	RK
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	ath with 23a or		130 SLADE A	VENU	E,#605			21	1208					USA	Journal y 1	
900	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Exaciner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ 3 ◯ Widowed 4 □ Divo		12. Was Deced Armed Ford 1 TYYes If Yes, Giv Year or Da	ces? 2  No e		Was Decedent fYes, specify 1 □Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ar Black, Wh Specify:		
Baltimore, Maryland 21215-0036	e. an "	Completed	15. Dec (Specify only h Elementary/Secondary (0-		ducation ade completed) College (1-	4or 5+)	(Give	dent's Usual O kind of work d DO NOT use re NER	one du	uring most	of worki	ng		GROCERY		
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, Mar	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Rela				2324	SUGARCO	NE					or Town, State		
imore	permit. Pages 1: Department of He Important: If iten any injury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Crema  Denation 5 ☐ Oth			tate W00	SESt MO DMOOR	ALBREW	Place	5		<sup>2009</sup>	ľ	IMORE,		State
Balt	permit Depart Import any inj		21. Signature of Funeral S	los	Kem	in	8	900 REI	STE	ERST0	WN R	OAD -	PIKE	& BROS	, MD	21208
	Physician	8. 1	23a. Part1. Enter the disease shock, or heart failure.  Immediate Cause (Final disease or condition resulting in death)	e, or con List only	one cause on ea	used tile deat chine. ONARY			f dying	, such as	cardiac (	or respiratory	arrest,		App Inter Ons	roximate rval Between et and Death
8760,	Medical Examiner physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b. CORO Due to (d	r as a conseq	RTERY 1 uence of). VE ART	DISEASE		DTIC	CARD	OIOVASC	ULAR	DISEAS	SE	
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tal Reco	in: The law re ificate has bee or, page 2 sho	Completed	25. Was case referred to me	dical						00. Plane	-4 D1	per 1 □ Yes	opsy formed? 2 last	prior t death	o complet	indings available tion of cause of No
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 Hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To Be	examiner? 1   Yes   2   No  27. Manner of Death   Vatural   5   Pe		28a. Date o	patient 2 f Injury i, <i>Day, Year)</i>	ER/Outpatier 28b. Time of Injury		Other	r: 4 1 Nu	rsing Ho	n <i>(Check only</i> me 5 ☐ Res 28d. Describe	sidence	6 ☐ Other (S)	pecify)	
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	To the Hospital within 24 hours a To the Funeral completely filled	Medical			hysician: To the I miner: On the ba and mann	sis of examina										
	To t with To t	Σ	29b. Signature and title of ce	rtifier	Ingell	) ju		29c. Li	cense	number	*		29d. D	ate signed (Mo	onth, Day,	Year)
			30. Name and address of pe		L, M.D.		FALLS	Print)  ROAD	STE	200.	LU'	THERVI	LLE,	MD 21	093	
	Stat Registra		31. Date filed (Month, Day,	(ear)	32. Re	gistrar's Signa	ture	1								

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** PM Murk VINTINIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City The Johns
5. Social Security Number ttopkins HUSDITA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🛛 F 40 Vrs Director 218-80-6561 09/27/1968 Baltimore, MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show Director MD Baltimore Parkville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9619 Mason Avenue 21234 U.S.A. Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Law Firm 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be f and Mental I Richard H. Murk Kathleen M. Roemer ပ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. Kathleen Murk/Mother 4710 Everlea Court, Preston, MD 21655 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/25/09 Forest Hill, MD 4 ☐ ponation 5 ☐ Other (Specify) Chapel-Bel Air Evans Fineral Chapel & Cremation Services 8800 Harbrd Rd. Parkville, MD 21234 21. Signsture of Funeral Service Licensee 23a. Pa 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed ate Cause (Final diseas e or condition resulting in death) **Physician** ntracerebra days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any line in manager cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Moua page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**%** No 1 Tes 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Manth, Day, Year) --26 2009 DHMH 17 Rev 1/2001

Matthew

2

Koen;

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0063682

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 408 PM Month 2009 HEKIA **Physician** MCCAULE 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BON SECOURS NA BALTIMORE HUSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1 M 2 F Days Year) Min 34 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☑Yes 2 ☐ No Funeral Director MO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2122 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2☑No <u>م</u> 3 Widowed 4 Divorced American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) abore arner 11th Grade NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 23 19a. Informant's Name/Relationship (Type. Print) Baltimore Brown Avenu Antonio inmount 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ansdowne MD 05-28-09 4 ☐ Donation 5 ☐ Other (Specify) Zion Willie Funeral Home P. A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** days /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) been signed by the a should be detached f 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performed? Yes 2 No 1 ☐Yes 2 No 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hou To the Fune completely fi

of death (Item 23a) (Type, Print) 30. Name and address of person who complete 2000 W. BALTMORE ST. BALTIMORE M.C. EVADNE MARCOLIN

31. Date filed (Month, Day, Year)

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** TEADOR WILLIAM ZEUG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Season's Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 07/12/ 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 215-48-9082 1 ☐ M 2 ☐ F 54 Months Days Hours Min Country) MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It. Mental Eventure Traumatic event, It. Mental Eventure Traumatic event, It. 10d. Inside City Limits 10h Count 10c. City, Town or Location iral", or items 23a or 28a-f show Evarierer must be notified at Baltimore Windsor Mills MD Funeral Director 1 Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 USA 3612 Coronado Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Completed by If Yes, Give Year or Dates: Specify. Specify: White 3 ☐ Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Operator Finances 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Lee Meador Patricia A. Shipley ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3612 Coronado Road, Windsor Mills, MD 21244 Patricia White / Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If
any Injury or
once. Ardent Crematory 5/25/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD Maisla Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** hock disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Funeral Director: After this certificate has been signed by the attending physician and siely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Yeer 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA . Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital within 24 hours a To the Funeral D completely

29a Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address son who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mo. State Registrar

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

1 - For State Registrar

			1. Decedent's Name (First, Middle, La.	st)				2. Date of De		Vaar	3. Time of Death
	Physic /Medi		JOHN A. MILLARD					Month MAY	21 2	1009	2:15P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, given MANOR CARE~ROSSV	·			r Location of Death			y of Death	IRE
	Funeral Director		5. Social Security Number 6. S 105~28~1514	M	in yrs. last birthday) '3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year) 8,1935	9. Birthp Court N - Y	place (State or Foreign htry) N.Y
			Usual Residence of Decedent	,				WOVIL	0,1000	1111	
	yland	,	10a. State 10b. County		0c. City, Town or Lo					1	0d. Inside City Limits
	e Mar 8a-f s	Director	Maryland Baltim	ore	Balt	cimore Co	unty				1 □ Yes 2 🕅 No
	swithin 72 hours after death with the Maryland glene. In than "natural", or items 23a or 28a-f show the Medical Evarriner must be notified at the Medical Evarriner.	al Dir	10e. Street and Number  9 Haylock Ct. Ap	t. 204		10f. Zip Code	21236	i	10g. Citizen of	JSA	ntry?
	deat	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	14. Ra	ce - Americ	
036	urs after al", or it	by	1 ☐ Never Married 2 ☐ Married  XX Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2√2No If Yes, Give Year or Dates:		1 □Yes 2 🛛 No	Specify:		Speci	1.	Vhite
2-0	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	fucation	16a. Dece	dent's Usual Occup	pation during most of work	kina	16b. Kind of E	Business/In	dustry
21	within 7 iene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT use retire	d)	Mig	Robb	Pook	
21	filed wi Il Hygier other th		8 yrs.	N/A	wa.	ll St. Cl	.er.k	- /Final Middle			
and	ould be fill Mental H arked otl atic ever	Be	17. Father's Name (First, Middle, Last, William Millard				Mary Ga	'	, walden Suma	mej	
Σ̈́	should be and Menta s marked umatic ev	2	19a. Informant's Name/Relationship (	Time Print)	10h Maili	na Addrona /Straat	and Number or Ru	- ' '	or City or Town	n State Zir	n Cada)
Ma	nd 2 sho alth and 27 is ma		John Millard (So	**	1	Leslie A		altimore			3 000007
ē,	Teg He		20a. Method of Disposition		20b. Place of Dispo cemetery, cre			Date	20c. Location		own, State
Baltimore, Maryland 21215-0036	permit. Pages Department of Important: If it any Injury or o		1 ☐ Burial ŽŽ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Specit</i>		Metro Ci	rematory,	<sup>ce</sup> / Inc. 5 <u>+</u> 23	3≠09	Baltin	nore,	Md.
3alt	permit. Depart Import any Inj once.		21. Signature of Funeral Service Licer	17 /	1		Funeral H				
	0.D = 0 0		23a. Part 1. Enter the diseas for com	pern			air Rd. B			- 1	Approximate
			shock, or heart failure. List only	one cause on each line.	^		rig, sucii as cardiac	or respiratory a	illesi,		Interval Between Onset and Death
arte.	Physician /Medical		disease or condition resulting in death)	a		CVD					
and the second	Examiner			Due to (or as a o	consequence or).						
١.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a o	consequence of):						
K	ecuted nd ransil	Examin	that initiated events	c							
30,	De execian a		resulting in death) Last	Due to (or as a o	consequence of):						
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	cian/Medical	•	d							
×	certif nding se as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				23d. D	ate of deliv	/erv
0. Bc	Q @ Q	siciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3 me of death 5	☐ Ectopic pregnand ☐ Other (specify) _	су			/onth	Day Year
σ.	hat th	Physic	9 Unknown  Part II. Other significant conditions		not resulting in the u	ınderlyina cause ai	ven in Part I	23e. Did	tobacco use co	ntribute to 1	the cause of death?
of Vital Records,	law requires that the d as been signed by the 2 should be detached	by	Tatti. Other agrimount conditions	ontributing to death but	not resulting in the c	inderlying cause gr	ventini arti.				bably 4 nknowr
COL	v requ been shouli	Completed						24a. Was	an 24h	Were aut	opsy findings available
Re	e las has je 2	dmo						auto	psy ormed?	prior to co death?	ompletion of cause of
tal	ician: Th certificate ector, pag	e C	25. Was case referred to medical				26. Place of Dea	1 Yes	2 No	1 □ Yes	2 No
<u> </u>	Physician: r this certific ral director, p	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatie	nt 3 DOA Ott	hor:	lome 5 ☐ Res		ther (Spec	ifv)
סר	ig Phr ter thi	T:U	27. Manner of Death	28a. Date of Injury (Month, Day,	28b. Time o				how injury occu		
Ö	Attending ir death. ector: After by the funer	atic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	n			]Yes 2 □No				
=	i ji fi	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, st (Specify)	reet, factory, office			(Street and Nun wn, State)	nber or Rui	al Route Number,
^	the Hospital hin 24 hours a the Funeral I mpletely filled		(Check only 2 Medical Example 12 Medical Example 2 Medical Example	nysician: To the best of miner: On the basis of e	xamination and/or is						
1	thin 2 the omple	Medical	29b. Signature and title of certifier	and manner state	d	29c. Licen	se number		29d. Date sigr	ned (Month	. Dav. Year)
	<b>5</b> ≥ 5 8		255. digniture and title of certifier			75	222		112	7 100	3
			30. Name and address of person who	completed cause of doc	th (Item 23a) (Tupo	Print)	ナイレブ	1	1/6	213	(
. • • •			A A A A A A	completed cause of dea	8812 W	ulthan	Wood	1 Ko	ed . W	10:	21234
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature		- V - V				-
	Regist	rar	MAY 26 200	Denve	A. Mar	Kad					
DHI	MH 17 Rev 1/2	2001			e.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

16727

			For State Registrar	State of Marylar		rtment of F <i>tificate of l</i>			leg. No. 2001	9 16728
			Decedent's Name (First, Middle, Last)					Date of Dea     Month		3. Time of Death
	Physicia /Medic		LYDIA	MATTH	EWS			MAY	19 2000	10:00PM
	Examin		4a. Facility Name (If not institution, give st		2	4b. City, Town, or	Location of Death		4c. County of De	
e Hj			BON SECO	0 1	PITAL	If Under 1 Year	TIMO)		O.B	N/A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	Vro	Months Days	Hours Min.	8. Date of Birth (Month, Day	( Year) 9. D	rthplace (State or Foreign Country) Maryland
	Director		212-20-2968 Usual Residence of Decedent	86	5			Jun 7,	1922	Iviaryianu
	/land		10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				10d. Inside City Limits
	Mar.	ctor	Maryland N/A			Ba	altimore			1 Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	-
	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jigal Examinational be notified at		2502 West Lanvale Street				21216			S.A.
	r dea	Funeral	11. Marital Status	<ol><li>Was Decedent Ever in U Armed Forces?</li></ol>	.S. 13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
36	or if	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 No If Yes, Give Year or Dates:	1	□Yes 21X No	Specify:		Specify:	Black
5-0036	hour tural	ed k	15. Decedent's Educa		16a, Deced	ent's Usual Occup	ation		16b. Kind of Busines	s/Industry
5	in 72 n "na A.clic	plet	(Specify only highest grade	completed)	(Give H	kind of work done of NOT use retired	during most of world)	king		School System
2121	filed within 7 I Hygiene. other than "r ent, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		T€	eacher		Dalumore S	School System
פ	e filed al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surname)	
<u>a</u>	should be filed within 72 hours after death with the Marylan mid Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show unatic event, the Maciest Examination as the notified at	To I	Raymond	Nelson					ola Gibson	
Maryland	al s		19a, Informant's Name/Relationship (Typ	e. Print)					er, City or Town, State aryland 21216	, Zip Code)
	1 and 2 Health em 27 other tra		Nelson Matthews  20a. Method of Disposition	20h				Date	20c. Location - City of	or Town, State
altimore,	Pages nent of ant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		sition (Name of natory or other place	1	05/29/09		ore, Md.
	it. Pa urtmel urtant njury		4 □ Donation 5 □ Other (Specify)  21. Signature 1 uneral Service Licenty			National Ce	_	03/29/09	Dattin	O16, WG.
Ba	permit. Page Department of Important: If any injury or once.		21. Salar diletal Service Liceria	1 950	an)		rothers Fune utaw Place B	ral Service,	P. A.	
			23a. Part 1. Enter the disease, or complic	ations that caused the dea	th. De not ente	1300 Exer the mode of dyir	<b>utaw Place B</b> ng, such as cardiad	attimore, Mo or respiratory ar	121217 rest,	Approximate Interval Between
	Physician		shock, or heart fallure. List only one Immediate Cause (Final		enticonstantino y	- 110	Diniaco	11/10	DESTACE	Onset and Death
9	/Medical		disease or condition resulting in death)	Due lor as a consec	quence of):	CAIC	DIOUFF	ALG	DISEASE	
	Examiner		,	END SF	AGE	RENA	L D19	SEASE		
	ב פ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consec	rd.					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	SEPT		NIA				
90,	The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a consec	quence oi):					
58760,	physi the t	edical	d.	20					14-	
×	eath certific attending p for use as t	/We	IF FEMALE: 23	Bc. If yes, outcome of pregn	nancy				23d. Date of o	delivery
Box	atter atter for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet. 4 ☐ Pregnant at time of	aldeath 3 □	Ectopic pregnand Other (specify) _	су		Month	Day Year
Ö	at the de by the tached	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9 🗌 Unknown						
α. σ.	w requires that s been signed b should be deta	by P	Part II. Other significant conditions conf	iributing to death but not re	sulting in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
Records,	quire en sig uld b							1 🗆 Y	∕es 2 No 3 □	Probably 4 hknown
၁၁	e law re has be re 2 sho	Completed						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
ř	The ate h page	ĕ						perfo	rmed? 🚽 death	
Vital	sician: The la certificate ha irector, page 3	Be (	25. Was case referred to medical examiner?					ath (Check only o	ne)	
_	hysion this coal direct		1 Yes 2 Do	ospital: 1 patient 2			4 LI Nursing F		dence 6 Other (S	pecify)
Division of	Jing F	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju Wor M 1	ryat k? ]Yes 2 □No	28d. Describe r	now injury occurred	
<u>S</u>	death death ctor: y the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	nome, farm, stre		1163 2 110	28f. Location (5	Street and Number or	Rural Route Number,
<u> </u>	ial or Attendii s after death. al Director: A ed in by the fu	Certification: To	4 ☐ Homicide determined	building, etc. (Spec	ify)	,		City or Tov		
	<b>₹5%</b>		29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge, death	occurred at the t	ime, date and plac	e, and due to the	cause(s) and manner	r as stated.
)	To the Hosp within 24 ho To the Fune completely f	edical	(Check only 2 Medical Examir one)	ner: On the basis of examinand manner stated.	nation and/or in					
V	Vithi To th	Σ	29b. Signature and title of certifier	1 1. 0		29c. Licens		I	29d. Date signed (Mo	
			Kopita K.	Cruz,	m. />	100	03035	7	may 1	9 2009
			30. Name and address of person who con	npleted cause of high (Ite	m 23a) (Type,	Print) BAKI	CERN	100 L	May 1	,
	. Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Sign	nature	10014	SE CO	11-5 /	USTITA	

Registrar



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan	-	ertificate of			Reg. No.	009	16	129
H	Physici	an	1. Decedent's Name (First, Middle, Las					Date of Dea     Month	Day	Year	3. Time of	
200	/Medic	al	Glenn Clark  4a. Facility Name (If not institution, give		annis	4b. City, Town, or	r Location of Death	5		2009 nty of Deat	0400 h	a <sup>M</sup>
model	CXdIIIII	ei	629 New Jersey Av	e. NE		Glen Bu				Arun		
ı	Funeral Director		231 20 7330	ex 7. Age (In yrs. 81	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da 2/3/19	th 28 <sup>(ear)</sup>	9. Birt Co	hplace (State of OHIO	or Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or L	ocation		-			10d. Inside C	ity Limits
	a-f sh	cto	MD Anne Art	undel	G1en	Burnie					1 □Yes	2 <b>X</b> No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen		untry?	
	eath w	eral	629 New Jersey Av	e NE  12. Was Decedent Ever in U.	S. 13.	21060 Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No		SA Race - Ame	rican Indian,	
2-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatte event, the "kedeal Evarine must be notified a	Ş	1 ☐ Never Married 2 ☐ XMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No		Rican, etc.)	E	Black, White		
15-0	"natur	letec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	oation during most of work	ing	16b. Kind of	f Business/	Industry	
2121	within piene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ply Office			Milit	ary		
Maryland 2	0 8	To Be C	17. Father's Name (First, Middle, Last) Jesse McMannis				18. Mother's Name Marie Be		Maiden Surr	name)		
	and 2 shoualth and N		19a. Informant's Name/Relationship (7 Mrs Mary McMannis		1	ling Address (Street New Jerse						
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic en		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	Place of Disp cemetery, cre Vetera	position (Name of ematory or other place ins Cemete	ery 5/28/	<sup>2009</sup>	20c. Location	-	Town, State	
Balt	permit. Departitingorts any inj	0.00	21. Signature of Fun and Sarvice Liber	M013	64 4	22. Name and Addre	ess of Facility Ki Hwy SE G	rkley-R len Bur	uddick nie MD	Fune 2106	ral Hon l	ne
L			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death	h. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximatinterval Be Onset and	tween
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a OstEomy		/					3 1/8	ARS
A.	Examiner			Due to (or as a constant)	uence of:	cene les	ves Ex	TREm.	17180	.	7 YEA	4R5
	pa tis	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	uence of):	cens lei Meuitu	AND F	RESAC	RAL		2016	
	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq		18684174	.5				201	EARS
68760,	ate be nysicia ne buri	Medical I		d								
	certifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancu				1			
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age is should be detached for use as the burial-transit.	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 Live birth 2 Feta 4 Pregnant at time of c	I death 3	☐ Ectopic pregnand ☐ Other (specify) _	ру		23d.	Date of de Month		Year
S, P.	n requires that the dibeen signed by the should be detached	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the	underlying cause giv	ven in Part I.				o the cause of	1
ecords,	requir	eted	1-11	BSTRUCTIVE	44	Ng DI	Aug L	11/(1)			robably 4 🗌	
r		Completed	CHRONIC K	INNEY DIS.	10 VAS EA-5 E	uion I	VISEAS	24a. Was autor perfo 1 ☐ Yes	psy prmed?		utopsy findings completion of	
Vital	Attending Physician: ir death. ector: After this certific by the funeral director, I	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outnatio	ent 3 DOA Oth	26. Place of Deat ner: 4 ☐ Nursing Ho	1 .		Other (Sp.	acity)	
n of	ng Phy fter thi		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month/Day, Year)	28b. Time Injury		ry at AIA	28d. Describe				
Division	ttendi death. :tor: A r the fu	icatio	2 Accident investigation 3 Suicide 6 Could not be	N/H	N/A		lYes 2 ☐No	N/A 28f. Loc tion (	Ctroot and No	umbas as D	ural Pouto Nu	mhor
Div	al or Attences after death I Director: Id in by the	Certification:	4 ☐ Homicide determined	building, etc. (Specif	N//	lreet, factory, office		City or To		miber or n	urai rioute ivui	nber,
	To the Hospitat or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	ledical (	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	nysician: To the best of my known in a communication in the basis of examination and manner stated.	owledge, dea	ath occurred at the ti investigation, in my (	ime, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and date and pla	d manner a	es stated.	(s)
_	To the I within 2 To the I complet	ž	29b. Signature and title of certifier	man m	1	29c. Licens		_			th, Day, Year)	120
)			30. Name and address of person who	completed cause of death (No.	n 23a) (Time	DOO Print)	25 775		05	- 21	- 700	71
	15 V	•	MELVA J. BROWN	NMD. 3100	ature (Type	DOO MAN PA	RK DRIV	E; BAL	TIMU	RE, N	10 21.	2//
	Sta Registr		31. Date filed (Month, Day, Year) MAY 26 20	109 Seneva	1. 1	barks						

DHMH 17 Rev 1/2001

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amend #5 Per FH C893 7/01/09 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Sharon Ann Mayes OZZZ AM May 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Hospita Agnes Itimore If Under 1 Year | If Under 24 Hrs. Social Security Number 218-46-3090 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days Months 1 ☐ M 2 🛱 F 62 July 25, 1946 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1004 Ingleside Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐Yes 2 ☑ No Specify Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator <u>Medicine</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Fleury Norma Armstrong 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Fleury Sister 1004 Ingleside Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory | 5/28/2009 Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that cause the death. Bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsville Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal 24 hrs ALVIE Due to (or as a consequence of): Septic shock Sequentially list conditions, if any, leading to innectate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNKNOWN Quality (or as a consequence of) Unknown Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown tailure 24a. Was an 24b. Were autopsy findings available

Box 68760. P.O. Records, Mayos Vital Division of

Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-tran attending physician for use the detached ģ signed director, page 2 should certificate After this completely filled in by the funeral 24 hours after death e Funeral Director:

within 2 To the I

Physician

/Medical

Examiner

Director

Funeral

9

Completed

Be

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Examiner

Physician/Medical

3

Be Completed

Medical Certification: To

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machael Eventer 200.

**Physician** 

/Medical

Examiner

			performed? 1 ☐ Yes 2 ☑ No	death? 1 ☐ Yes 2 ☑ No
25. Was case referred to medical		26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 🗹 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	☐ DOA Other: 4 ☐ Nursing Hom	e 5 Residence 6	☐ Other (Specify)
27. Manner of Death 1 ☆Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	Work?	3d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be determined		ctory, office 28	Bf. Location (Street and City or Town, State)	f Number or Rural Route Number,
	hysiclan: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.			
29b. Signature and title of certifier	73	29c. License number	29d. Date	e signed (Month, Day, Year)

021994

5/23/09

State Registrar

31. Date filed (Month, Day, Year) 26 2009

Natalie

MD 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caton

Registrar

2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 4:53 PM M 2009 May 21. Carol Α. Petersen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince George's Clinton 8. Date of Birth (Month, Day, Ye) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Year Hours Months 1 □ M 2 🗓 F 1945 Stafford, CT 049-36-5582 63 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show 1 Yes 2 No Director Palm Beach Florida Jupiter 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 33478 U.S.A. 15106 121st Terrace Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 <sup>Specify:</sup>White 1 ☐ Yes 2 ☑ No Specify. ۵ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "any Injury or other traumatic event, the Meany Entre. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen Hajostek Mary Zigaldo ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FL 33478 Bruce Petersen (Husband) 15106 121st Terrace, Jupiter, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Edward Cemetery Stafford Springs, CT 4 ☐ Donation 5 Other (Specify) 5/28/09 21. Signal re of Juneral Service Linns 22. Name and Address of Facility Introvigne Funeral Home 51 East Main St., Stafford Springs, CT 06076 Minn ennes! 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEAGE **Physician** disease or condition ACUTE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 H Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐Yes 2 ☐ No Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ton. MD Mak 050689. 05/22/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 🔑 NIL K, MAHAT 🧼 MS, SOUTHERN MANYL HUIDITAL CENTER 7503 SUPLEATIZED CLINTUNM DJ0735.

DHMH 17 Rev 1/2001

State

Registrar

AND

32. Registrar's Signature

31. Date filed (Month, Day, Year)

MAY 26 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

16733

Physic /Med Exami

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination to rottled at any injury or other traumatic event, If a Medical Examination to rottled at appear.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Registrar	Cer	rtificate of L	realli	F	leg. No		
	1. Decedent's Name (First, Middle, Last)				2. Date of Dea			3. Time of Death
ian	Earl Raymond Phinney Jr.				Month May	22, 2	2009	11:55 PM
cal	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death		4c. County		
ner	4715 East Lane		Baltim			N,	/A	
		e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birti	1	9. Birthpla	ace (State or Foreign
	036-12-3884 <sup>1</sup> X M 2□ F	88 Yrs.	Months Days	Hours Min.	(Month, Day Nov 3		Countr	Island
	Usual Residence of Decedent	00			1100 3	1720	Miode	ISTAIR
	10a. State 10b. County	10c. City, Town or Lo	cation				100	d. Inside City Limits
ē	Maryland N/A	Balt.	imore					1X Yes 2 □ No
Je C	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Countr	y?
Ö	4715 East Lane		21210			USA		
era		Ever in IIS 13 V			ecify Yes or No-		ce - America	n Indian
Ë	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Armed Forces?  1 □ Yes 2 □ I	no 1942	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Bla	ck, White, et	
5	3 Widowed 4 □ Divorced Sear or Dates:	1946	1∐Yes 2XXINo	Specify:		Specif	v: Whi	te
pa	15. Decedent's Education		dent's Usual Occupa	ition		16b. Kind of B	Jusiness/Indu	ıstrv
ete	(Specify only highest grade completed)	(Give	kind of work done di DO NOT use retired)	uring most of worki	ing			,
ΙĔ	Elementary/Secondary (0-12) College (1-4or 5	Ban Ban	_			Ban	king	
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	_		
					. Taylo			
P	Earl Raymond Phinney Sr.  19a. Informant's Name/Relationship (Type. Print)	10h Mailie	ng Address (Street a	-			State Zin /	Cada)
	Linda Paisley, Daughter							3000)
-			East Lane		ce, Mary	20c. Location		un State
	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		osition (Name of matory or other place	9)			•	
	4 ☐ Donation 5 ☐ Other (Specify)	Metro Cre						Maryland
	21. Signature of Funeral Service Licensee Thomas	Gregor 2	2. Name and Address remation 99 Freder	s of Facility Society (	of Marvi	land. I	nc.	
	Nomew Yun	l Ž	99 Freder	ick Road	Baltimo	ore, Ma	ryland	1 21228
	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one couse on each li	the death. Do not ent	ter the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
		MIJOCAR	DTM	TANTAN	1070	<b>A</b> 1		Onset and Death
	resulting in death)  a.  Due to (or as	a consequence of):	-O T W -		~. ~	• •		10000
	6600	NI DEN	AL DIC	EASE S	TAGE	W		10 year
je l	Sequentially list conditions, D.	a consequence of):		, -				3
	if any, leading to immediate Due to (or as	a consequence or).				200	- 4	
E.	course Enter I Inderlying	,	221	AUTOTA	SCULAR	L VEX	2455	20 year.
Examir	that initiated events	a consequence of):	MC CA	AUDIOUA	SCULAR	L VEX	ENS	20 year.
al Examir	that initiated events	TOSCIENO	M2 4	AUUIDA	BCULAR	L VEX	SAS	20 year.
edical Examir	that initiated events	TOSCIENO	MC CA	AUTOUA	SCULAR	L QES	EAUS.	20 year.
n/Medical Examir	Cause (Disease or Injury that initiated events resulting in death) Last  C. Due to (or as d	a consequence of):			SCULAR			20 year.
cian/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as d	of pregnancy	☐ Ectopic pregnancy		BCULAR	23d. D	ate of deliver	ry Day Year
	Gause (Disease or Injury that initiated events resulting in death) Last  C. Due to (or as d	of pregnancy			SCULA!	23d. D	ate of deliver	•
	Gause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No   No   No   No   No   No   No	a consequence of):  of pregnancy 2 ☐ Fetal death at time of death 5 [	□ Ectopic pregnancy □ Other (specify)	,		23d. D M	ate of deliver	•
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 26 2009

Backs

32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #21 Per FH g891 to 100 and Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 18, **Physician** 2009 James Pryor May 4:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 4207 Valley View Avenue Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 1 | 5, 1961 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** New York 1 X M 2 □ F 48 089-52-1797 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1XXYes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 4207 Valley View Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: XXNever Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Database Administrator District of Columbia permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other th any Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond J. Pryor, Jr. Jean Stewart 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4207 Valley View Ave. Baltimore, MD 21206 Mr. Wayne Himes / Partner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/26/2009 Hillton Service Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01466 5305 Harford Rd. Baltimore, MD 21214 per DVR Leonard J. Ruck, Inc. Alexandria J. Blair 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To ∕ 2 📝 No 1 TYes 1 [] Inpatient 2 ER/Outpatient 3 DOA 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🛮 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death Director: within 24 hours a To the Funeral C

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

or 28a-f show

items 23a

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"natural",

than

Examiner must be notified at

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. ture and title of certific 30. Name and address of person who completed cause 32 Registrar's Signature 31. Date filed (Month, Day, Year) 26 2009

State Registrar

State of Maryland / Department of Health and Mental Hygiene?

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea 45 PM Month Physician /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner zrd more If Under 24 Hrs. 9. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 200 F 9-22 Yrs Director 10000 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23s or 28s-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number là 12 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify. þ 3 Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THUSband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2rd 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Injury or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donetion 5 □ Other (Specify) Viemoria 22. Name and Address of Facility 21. Signature of Funeral Service Licenses any l Home us Joseph Ave North Ba 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical arcia Owa Examiner Due to (or as a consequence of) Physiclan/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, physician Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 3No 1 ☐ Yes 2 ☐ No this certificete 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Il Director: After this ad in by the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Alaturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter deeth.

To the Funeral Director: Af investigation Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 22,2009 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) LOMAN 12 21202 31. Date filed (Month, Day, Year) 32. State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 2:13 P M May 19, 2009 Reinhart /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Dec. 7, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 🕅 M 2 🗆 F 1942 New York Director 138-34-8768 66 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 20876 'natural", or items 23a U.S.A. 21331 Emerald Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify à Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Operations Manager Neiman-Marcus 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Reinhart Helen Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Reinhart (Wife) 21331 Emerald Dr., Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2. Cremation 3 Removal from State 4 Donation 5 DOther (Specify) 5/22/09 West Ridgelawn Cem Clifton, NJ 22. Name and Address of Facility
Allwood Funeral Home 21. Signature of Funeral Service License 660-670 Allwood Rd., Clifton, NJ 07012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Cardiac Pulmonary Arrest /Medical Due to (or as a consequence of): **Examiner** Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X** No 2 🗀 No 1 □ Yes 1 TYes Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 📉 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Vital

Division of

State Registrar

Qiufang Cheng, MD 9901 Medical Center Dr., Rockville, MD 20850 31. Date filed (Month, Day, Year)

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D0065505

2009

			For State Registrar	State of Maryla	•	artment of F r <i>tificate of l</i>			ene g. No. 2009	9 16737
	Physici	an	1. Decedent's Name (First, Middle, Last		D .			2. Date of Death Month	Day Year	3. Time of Death
· Stanfall	/Medic Examin		Angela S. 4a. Facility Name (If not institution, give		Kouser	4b. City, Town, or	r Location of Death	03	4c. County of Dea	
- 1	ZX		BON SECURS H	05PITAL		BALTIM			NA	
	Funeral Director		5. Social Security Number 6. Se 2 2 0 - 6 6 - 1 5 6 5	7. Age (In)	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign ountry) MD
	סי		Usual Residence of Decedent						- 34	
	arylar show	7	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	M D N A  10e. Street and Number	В	altimo	r e 10f. Zip Code		10	g. Citizen of What Co	Λ
	h with	Funeral Director	808 W. Lexingt	on Avenue		21201	l		USA	
	r death	nuer	11. Maritar Otatas	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Medical Examirum must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ∐ Yes 2√F No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify: B	lack
5-0036	72 hou nature	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occup	eation during most of work	ina 1	6b. Kind of Business	/Industry
21	within ene. <b>than</b> "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired e1 worke	d) -		o + h l o h o r	n Steel Co.
d 21	filed within Hygiene. other than "ent, the Me		12th Grade  17. Father's Name (First, Middle, Last)	N A	Sie	er worke	18. Mother's Name		-	n bleer oo.
Maryland	ould be t Mental arked o atic eve	To Be	Jerry V. Rous	er			Susan	Whi	te	
lar)	2 should and Mer Is marke aumatic		19a. Informant's Name/Relationship (T)	rpe. Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Number,	City or Town, State,	Zip Code)
ē,	1 and Health sm 27 ther to		Susan Rouser-Me  20a. Method of Disposition						altimore Oc. Location - City or	MD 21201
nor	ages ent of it: If It y or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ F	removal from State		osition (Name of matory or other plac rematór			Baltimor	_
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra once.		21. Signature of Funeral Service Licens			2. Name and Addre	J		neral Hor	ne P.A.
<u> </u>	8 g T g		1/M/ry	he			ilmor St	reet_Ba	altimore	MD 21217
			23a. art 1. Enter the disease, or mpl shock, or heart failure. List nly o				ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
The state of	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con:		SHOCK				4B hours
7	Examiner		Constant the Person of Marie	BACTERE						
	ed sit	iner	Sequentially list conditions, if a.m. reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		sequence of):	10.50				
	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a con-	DRUG sequence of):	ABUSE				
68760,	ite be iysicia ne buri			d						
89 >	ertifica ling ph e as th	Med	IF FEMALE:					-		
Вох	leath certific attending p	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death 3	☐ Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
P.0.	t the d by the ached	hysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknown						
S, E	uires that the de signed by the a d be detached f	by P	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.			to the cause of death?
ord	w requir been s should								s 2 No 3 F	
Records	ne law e has t ge 2 s	Completed				-		24a. Was ar autopsy perforn	prior to ned? death?	
ta	ician: The certificate ector, pag	ပိ	25. Was case referred to medical				26 Place of Deat	1 ☐ Yes 2 th (Check only one	No 1 □ Ye	s 2 No
of Vital	nysici nis cer direct	To B	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 XInpatient 2	2 ☐ ER/Outpatie	nt 3 DOA Oth	OW.		nce 6 ☐ Other (Sp	ecify)
0 0	Jing Pi J. After ti funeral	on:	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	r) 28b. Time of Injury	Wor		28d. Describe ho	w injury occurred	
Division	or Attend after death Director: /	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, st		lYes 2 □No	28f. Location (Str	reet and Number or F	Rural Route Number.
Σ	al or A s after al Director	Certification:	4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)	oo, .ao.o.,, coo		City or Town		,
	To the Hospital or Attending Physician: The law requires that the death certif which 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		(Check only 2 Medical Exam	sician: To the best of my ner: On the basis of exar						
	ithin 2 orthe	Medical	29b. Signature and title of certifier	and manner stated.	<del></del>	29c. Licens	se number	25	9d. Date signed (Mor	nth, Day, Year)
	⊢ ≶ F ŏ		Fradre- War	din M	0	FM	096970	9	05/17/	2009
	11		29b. Signature and title of certifier  Wadu Ward  30. Name and address of person who concerns the concerns of	ompleted cause of death (	Item 23a) (Type,	Print)			1	21723
			EVADNE MARCOLINI	BON SECUL	es Hospi	TAL ZO	OO W. BAD	TIMORE	ST. BAU	more, mo
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's S	ature	11				

DHMH 17 Rev 1/2001

			For State Registrar		State o	f Maryla		artment of F <i>rtificate of</i>	Health and N <i>Death</i>		giene Reg. No. 2	009	16738
	Physici	_	Decedent's Name (I     Alma	First, Middle, Las	<i>'</i>	orothy		Rı	udiger	2. Date of Dea Month May	ath Day 24	2009	3. Time of Death  2:45 A M
4	/Medic Examin	20 30	4a. Facility Name (If no	_	street and nu	-			or Location of Death	J		ty of Death	2043 11
	en Som Agree en		Future Ca		-	7 4 //-	la a 4 fe laste ata a 1	Arnold If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th.	ne Aru	
San in	Funeral Director		5. Social Security Num 212-05-017	0 1	ex □M 2ÅTF		s. last birthday) 91 Yrs.	Months Days	Hours Min.	July 1	y, Year) ,1917	Cour	place (State or Foreign htry) MD
	and w		Usual Residence of De 10a. State	ob. County		10c. (	City, Town or Lo	ocation				1	0d. Inside City Limits
	Maryi -f sho fied a	tor	MD A	nne Aru	ndel		Arno1	d					1 ☐ Yes 2X No
	th the or 28a e. noti	irec	10e. Street and Numb	er		1		10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	ath wii 23a ust b	ral	305 Colleg	e Park				21012			U.S.A.		
36	be filed within 72 hours after death with the Maryland tital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married  3 □ Widowed 4		Armed F	Z∕∏ No ive	U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 【X No	dispanic Origin? (Span, Mexican, Puert Specify:	pecity Yes or No o Rican, etc.)	Spec	ace - Americ lack, White,	
215-0036	n 72 hou "natura edical E	Be Completed I	1! (Specify	5. Decedent's Economy highest gra	lucation de completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor d)	king	16b. Kind of	Business/In	dustry
212	d within jiene.	omp	Elementary/Second	lary (0-12)	College (	1-4or 5+)		emaker	-7		Own H	lome	
٥	hould be filed and Mental Hygin marked other matic event, ti	3e C	17. Father's Name (Fi	irst, Middle, Last)					18. Mother's Nan	ne (First, Middle,	, Maiden Surn	ame)	
<u>Xa</u>		10 E	Robert B.	`						J. Smitl			
Maryland	n ar h ar r is		19a. Informant's Nam Mrs. Dian			aughte	I	•	and Number or Ru oor Drive				Code)
altimore,	Pages 1 and nent of Health int: If item 27 iry or other ti		20a. Method of Dispos 1 🖾 Burial 2 🔲 0	Cremation 3		State		osition (Name of matory or other pla	riay	Date 28,	20c. Location		
<u>=</u>	permit. Pages Department of Important: If it any Injury or once.		4 □ Donation 5 21. Signature of Fune		y)	N		edral Cen  2. Name and Addre	n. 20 ess of Facility Si		Baltim		
Ba	Per Ben		) U.C	2		N	OUZI S	ervcies I	P.A. 1 2n	d Ave. S	SW Glen		ie MD 21061
0 1	Physician		23a. Part1. Enter the shock, or heart t Immediate Cause (Fir disease or condition		plications that one cause on	caused the de	eath. Do not en	ter the mode of dyi	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death  UP OCS
7	/Medical Examiner		resulting in death)		a. Due to	(or as a cons	equence of):			-6	<u> </u>	(	9000
	ed isit	niner	Sequentially list cond if any, reading to immorause. Enter Underly Cause (Disease or in)	rediate	b. Cite to	(or as a corn	iequence of):						
o,	icate be executed physician and the burial-transit	Examine	Cause (Disease or inj that initiated events resulting in death) Las	st	cDue to	(or as a cons	equence of):						
38760,	cate be physicia the bu	dical			_d								
.O. Box 6	eath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	iontis?		birth 2□F nant at time o	etal death 3	□Ectopic pregnanc □ Other (specify) _	су			Date of deliv Month	ery Day Year
ds, P	w requires that the d been signed by the should be detached	by	Part II. Other signific	ant conditions of	contributing to	heath but not i	resulting in the u	underlying cause gi	ven in Part I.		tobacco use co Yes 2 □ No		the cause of death?
Records,	<b>sician:</b> The law req s certificate has beer irector, page 2 shou	Completed	due	70	chro	nic	hyp	perten	51'07	24a. Was auto perfo 1□ Yes		prior to co death?	opsy findings available ompletion of cause of
Vital	stan:	BeC	25. Was case referre	d to medical	2					ath (Check only		10100	20110
2	Physic this co	은	1 ☐ Yes 2 ☐ N				ER/Outpatie	all DOA		Home 5 Res			f(y)
ono	ding Pi h. After th funeral	tion:	27. Mann of Death  1 Matural  2 Accident	5 ☐ Pending investigation	,	nth, Day Year	28b. Time ( Injury	Wo	ork? ]Yes 2∐No	28d. Describe	now injury acc	curred	
Division or	I or Attendafter death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	e 28e. Plac	e of injury - A ding, etc. (Spe	t home, farm, si ecify)	treet, factory, office			(Street and Nu wn, State)	mber or Rui	al Route Number,
6	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C			miner: On the				time, date and place opinion, death occ				
•	To the To the Compl	Me	29b. Signature and tit	tle of certifier		1	`	29c. Licen	se number	٠ ح	29d. Date sig	ned (Month	, Day, Year)
-				1	1	6	MD	U	50/0		5-0	74-	2009
			30. Name and address	er Vie	completed cau	use of death (I	tem 23a) (Type	eteran	Huy	Mills	usvil	16/	41) 21/08
7	Sta Regist		31. Date filed (Month)	26 2009	Sens	megistrar's Si	1. par	Kel	0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Helen P. Suski **Physician** 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Days Mary land Months Hours Min. 214-20-3625 85 Director Nov. 17, 1923 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits purmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ore. 10a. State 10b. Counfy Harford Co. Bel Air 1 ☐ Yes XX No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 1330 Kingslynn Court United States Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ∏ Yes 2XX0 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specity: White þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done do life. DO NOT use retired) during most of working Baltimore City Elementary/Secondary (0-12) Crossing Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Zeller Daisy Frazier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2515 Laurel Valley Garth, Abingdon, Maryland 21009 Mrs. Mary Arigo (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/21/2009 Evans Funeral Chapel Forest Hill, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee Joz 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Leve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 1□ Yes 2 No Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 0 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After Division Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 056545

6 1

State Registrar 31. Date filed (Month; Day; Year) NAY 26 20

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KHOSCA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



BELAIR,

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Day Year 7:14 A M 21 2009 Joseph Sykes Stephenson May 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year 7/8/1931 Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 🔯 M 2 🗆 F NJ 577-42-8604 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXXNo Westminster MD Carroll 10g. Citizen of What Country? 10e. Street and Number 21157 IISA 2219 Timothy Dr. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married XYes 2 No If Yes, Give Year or Dates: 1948-54 1 ☐Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Lab Technician NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miriam Sykes George W. Stephenson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elsie H. Stephenson/Wife 2219 Timothy Dr., Westminster, MD 21157 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Prospect Hill Cemetery 5/27/09 Front Royal, VA 21. Signature of Funeral <sup>22</sup> Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final olon disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transil Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewore.

**Physician** 

Examiner

/Medical

Itimore,

Director

by Funeral

Completed

Be

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Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Sulcide

29a. Certifier

(0 X)

State Registrar

31. Date filed (Month, Day, Year)

6 Could not be

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D20907

Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 1/2001

Amend #1 & 4b per MD 8891 5/26/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month Day **Physician** 5:15 PM Schulman, Herbert Schulman May 2009 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randally town, Mary And Ba Himon Hespita Northwest 7. Age (In yrs. last birthday) State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplac Country **Funeral** Sex 1XIM 2□ F Min. Months Days Hours Director 215-03-8580 94 03/09/1915 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ust be notified at 1 □Yes XX No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 4204 OLD MILFORD MILL ROAD 21208 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after des Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, it. Wocies Examine: 11. Marital Status 14 Bace - American Indian 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 □ Yes XX No Specify. ģ 3XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER LIOUOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **SCHULMAN** SARAH **GOODMAN** ပ MAX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 BONNIE MEADOW CIRCLE, REISTERSTOWN, MD 21136 ELAINE LANG / DAUGHTER altimore, 20a. Method of Disposition Place of Disposition (Name of Date 20c. Location - City or Town, State MIKROWKODESH BETH 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CONG. 05/22/2009 ISRAFI BALTIMORE, MD 21. Signature of uneral Service bicense 22. Name and Address of Facility INC. 21208 8900 REISTERSTOWN ŔŪ Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Failure to Thrive, Oropharyngen disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration Se uential, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Encephalopat attending physician and for use as the burial-tran Box 68760 Physician/Medical Res Divatery requires that the death certificate IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 3 robably 4 ☐ Unknown Hypertension, colondry Artery Discare, 1 ☐ Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law Chronic Contractive cate has t autopsy certificate ! 5. as case referred examiner? Dispor 1 ☐ Yes 401-tic 1 ☐ Yes Hospital or Attending Physician: director. Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No inpatient 2 ER/Outpatient 3 DOA this Certification: To After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Feath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 Accident 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phy Medical Exami 29a. Certifier Medical ician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) of o 29c. License number 20, 2000 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randall town, Manland Va Xi Road old court 5401 Rupesh 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 09-03934 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK		State of Maryland / Depa	artment of <i>rtificate</i> o <i>f</i>		Mental		Reg. No.	20	009	1674
Physicia lical Exami	an/	1. Decedent's Name (First, Middle,Last)  Lucio Solorzano-Ale	or			2. Date of De Month May 17,	Day	Year	3. Time of 1914	
		4a. Facility Name (if not institution, give street and number) 7001 Reistertown Road		b. City, Town, or Lo Baltimore	ocation of D	eath	40	. County of I	Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1 X M 2 F 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of E	,	1	9. Birthplace (Sta Country) Peru	ate or Foreign
ow any			, Town or Locati							le City Limits
the Maryland a or 28a-f show any tified at once.	Director	MD   10e. Street and Number 3 Amleht Court T2		Baltimore 10f.Zip Code 2121			10g. Citi	zen of What	Country?	
er death with , or items 23 r must be no	Funeral	11. Marital Status  1 Never Married 2 X Married  3 Widowed 4 Divorced If Yes, Give Year	If Y	s Decedent of Hisp es, specify Cuban, Yes 2 No			10-	14. Race - White, e		
BAILLINGOF, INID XIXID-0030 permit. Pages 1 and 2 shoulde filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	leted by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Deceden during m	t's Usual Occupationst of working life. I	on (Give kind			Kind of Busin	Hispan ness/Industry	1c
Z IZ IS-0030 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Completed	8 17. Father's Name (First, Middle, Last) Santos Solorzano		armer 15		lame (First, Middle	, Maiden	,	ure	
id 2 should b lith and Meni m 27 is marl aumatic eve	To	19a. Informant's Name/Relationship (Type, Print) Walter Solorzano Son	19b. Mailing	Address (Street nbleton R	and Number	r or Rural Route N Owings M:	umber, C ills	ity or Town, MD	21117	
Definition of the property of the permit. Pages I and 2 showed permit of Health and important: If item 27 is njury or other traumati		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: Ca	crematory or oth	remation	Ser	Date 5/22/09	Ha	mpstea	City or Town, Star	te
hysician		21. Signature of Funeral Service Licensee  23a. Part I. Enter the disease, or complications that caused the death	ELI	INE FUNER	AL HO	11824 Rei	erst	own, M	ID 2113	6 imate Interval
/Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Head and Neck Injurie Due to (or as a consequence of Sequentially list conditions,	of):							en Onset and Death
ited J ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of					166			
te be executed sysician and burial - transit	ledical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pre-	nancy				123	d. Date of d	elivery	
To the Hospital or Aftending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sicial	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 2 Unknown 2 Unknown	2 Fe	tal death 3 her (Specify)	Ectopic pr	regnancy		Month	Day	Year
ires that the de signed by the I be detached f	d by Phy	Part II. Other significant conditions contributing to death but not	resulting in the u	underlying cause gi	ven in Part I		_		ute to the cause	_
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ysician: The l his certificate director, page	o Be C	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2	ER/Outpatient		74h	neck only one) lursing Home 5	Resid	ence 6 🗸	Other: Scene	
In or Attending Physician: The law requiring after death.  In Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director.	-1	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury FOUND: Way 17. 2009	28b. Time of I FOUND: 1910 hrs		y at Work? es 2 ✔ No	28d. Describ Subject be		jury occurred	d	
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At to determined (Specify) Woods				or Town 7001 Reiste	, State) ertown F	Road , Balti		Number, City
To the Ho within 24 To the Fin completely	Medical	293. Certifier 1 (Check only one)  2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	dge, death occui and/or investiga	tion, in my opinion,	death occur	, and due to the ca red at the time, da	te and pl	ace, and du	e to the cause(s  d (Month, Day, Y	
		30. Name and address of person who completed cause of death (Itel	m 23a)	O.C.N				y 18, 200		
~		Ana Rubio MD. Assistant Medical Examiner	111 Penn 9	Street, Baltimo	re, MD 2	1201				
St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signar Signar	D. pa	Med						

			1 - For State Registrar	State of Ma	iryland / L		tment of H ficate of L		Mental Hy	gieni Reg. No		10/43	
- 5	•		Decedent's Name (First, Middle, Las	it)	0	,			2. Date of De	ath		3. Time of Death	
ų.	Physicia /Medic		Teg	59	NZH	1K			Month	Da / /	72008	834 AM	
1	Examin		4a. Facility Name (If not institution, give	street and number)	11	4	b. City, Town, or	Location of Deal	n /	40	County of Death	. ~.	
-			5. Social Security Number 6. Se	1+01p	(In yrs. last bir	rthdav)	If Under 1 Year	If Under 24 Hrs.		rth (	9. Birth	place (State or Foreign	
	Funeral Director			□М 2ДТ			donths Days	Hours Min.	(Month, Da Feb. 23	ay, Year	Cou	intry) Snia	
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	Many e-f sh	to	MD Balti	more	F	Reist	erstown					1 ☐ Yes 2 📉 No	
	be filed within 72 hours after death with the Maryland tall Hygiene. id other then "natural", or iteme 23a or 28e-f show event, I'm Medical Experimentment be notified at	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	untry?	
		rai	12 Wild Cherry C					21136			Bosnia	in a tagina	
36	rs after de r', or item varriner n	by Funerai	11. Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced	12. Was Decedent € Armed Forces?  1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			s Decedent of Hi es, specify Cuba Yes 2 No	spanic Origin? (S n, Mexican, Puerl Specify:	o Rican, etc.)	0-	14. Race - Amer Black, White Specify:		
Maryland 21215-0036	2 hou	ted	15. Decedent's Ed	ucation	16a	. Deceden	nt's Usual Occupa	ition turing most of wo	rking	16b. I	Kind of Business/l		
218	ithin 7 39.	Completed	(Specify only highest gra-	College (1-4or 5	+)	life. DO	NOT use retired	)	King		1 .		
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	s 1 and 2 should F Health and Men Item 27 ie marke other treumatic		Senad Sadzak	Father	12	2 Wil	d Cherry	Court,	Reister	sto	wn, MD 2	1136	
ore,	ges 1 a it of He if Item or othe		20a. Method of Disposition  1 X Burial 2 Cremation 3	Damoual from State	20b. Place o cemete	f Dispositi ery, cremat	on (Name of tory or other place	9)	Date	20c. l	ocation - City or	Town, State	
Ë	a 0		4 Donation 5 Other (Specify		All Sa	aints	' Cemete	ery 5/	20/09	Re	istersto	wn, MD	
Baltimore,	permit. Par Departmen Important: eny injury :		21. Signature of Euneral Service Licen	M. Jan	Kins		ame and Addres ne Fune	s of Facility			istersto town, MD		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do	not enter	the mode of dying	g, such as cardia	or respiratory a	arrest,		Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition									Onset and Death	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):										
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	w requires that the s been signed by th should be detache	Ď	Part II. Other significant conditions of	ontributing to death be	ut not resulting i	in the unde	erlying cause give	en in Part I.			N/	the cause of death?	
ecor	>	Completed							24a. Was		24b. Were au	topsy findings available	
<u>=</u>		Con							perf 1 ☐ Yes	ormed?	o death?	2□ No	
Vits	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			oCl pos Othe	oc.	ath (Check only				
ō	Attending Physicien: r death. ector: After this certific by the funeral director,	٦: T	1 ☐ Yes 2 No  27. Manner of Death	1 Anpatie	nt 2 ☐ ER/O₁ y 28b.	utpatient Time of	3 DOA 28c. Injury	4 LI Nursing F	dome 5 ☐ Res 28d. Describe		6 □Other (Specury occurred	cify)	
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Division of Vital Records,	or Atteater des Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At home, fac. (Specify)	arm, stree	t, factory, office		28f. Location City or To		t and Number or Rural Route Number, tate)		
_	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: Atter this completely filled in by the funeral di	edical C	29a. Certifier Certifying Ph	ysician: To the best on niner: On the basis of and manner sta	examination ar	e, death o	ccurred at the tim stigation, in my op	ne, date and place	e, and due to the urred at the time	cause(	s) and manner as nd place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier		i i		29c. License			29d. D	ate signed (Monti	h, Day, Year)	
	C>F0		) SCA	W h	4		-	3750		51	117/20	201	
-			30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Pr	int)	thues	1 12		.//	0:1-	
			J fever	J. July	ARTZ	115	Nor	Thues	J 170	05/	579L (	PHTER	
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James E. Smuck <sup>Day</sup> 2009 May 21, 6:45 A.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 218 Westshire Road Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 X M 2 □ F 218-38-3981 68 July 20, 1940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21229 USA 218 Westshire Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decessor Armed Forces? 1 □Yes 2 X No 14 Race - American Indian 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 XXNo White Specify ğ 3 Nidowed 4 Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Smuck Doris Barker ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon I. Oswald Daughter 158 Sanford Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 5/27/2009 Woodlawn, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Sepvice License 1630 Edmondson Avenue; Catonsville, 21228 23a. Part 1. Enter the disease, or complications that car sed the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic Due to (or as a consequence of) Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2**X**No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 12 Natural 5 Pending Injury investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ixertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

The law requires that the death certificate be executed Box 68760. Records, of Vital Division

**Funeral** 

Director

28a-f show

23a or 2

or items

Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
int: If Item 27 Is marked other than "natural", or ite

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau

**Physician** /Medical

Examiner

the burial-transit

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in by the funeral

Baltimore, Maryland 21215-0036

Examiner must be notified at

or Attending Physician: after death within 24 hours a To the Funeral C Hospital

> State Registrar

MIARVIN 31. Date filed (Month, Day, Year) 26 2009

29b. Signature and title of certifier

ELAMAN MI /32. Registrar's Signature

and manner stated.

CO 140

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

May 22, 2009

21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16b Pers and G8 Mar 5/26/09ep at tment of Health and Mental Hygiene, 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mo*n*th Year 7:30P M 05 0200 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 6998 MARSUE DRIVE #2A BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth NOV 8 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Months: Days Hours Min. 1 □ M 2 📈 F UKRATNE 88 214-63-6339 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County XYes 2 ☐ No BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 6998 MARSUE DRIVE #2A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. If Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) GOVENMENT LAWYER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KISELEVA SHATS MALKA YAKOV 19a. Informant's Name/Relationship (Type. Print) VLADIMIR KAGALNITSKIY/SON 19b. Mailing Address (Street and Number of Burne Number of Bur 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State BALTIMORE HEBREW 5/22/2009 REISTERSTOWN, MD 5 ☐ Other (Specify) 22. Name and Address of the lity LEVINSON & BROS., INC. Signature of Funeral Servi 8900 REISTERSTOWN ROAD-PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. if yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □Yes 2 □No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed Yes 2 1 🗆 Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Maritel Examinat must be reserved once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit

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Hospital or Attending Physician: The law requires that the death certificate be executed I hours after death. uneral Director: Af aly filled in by the fur To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Division of Vital Records, P.O. Box 68760

State Registrar

Medical

29b. Signature and title of certifier

5 Pending

investigation

6 ☐ Could not be determined

and manner stated

1 Inpatient

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No

26. Place of Death (Check o y one)

Other: 4 \( \subseteq \text{ Nursing Home} \)

28c. Injury at Work?

29a. Certifier Check only 2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

201 Milford milled; Pikesville MD21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2 2 2009

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar
DHMH 17 Rev 1/2001

**OCME 2006** 

State

Margarita Korell MD.

31. Date filed (Month, Day

**ORIGINAL** 

Assistant Medical Examiner

egistrar's Signatur

111 Penn Street, Baltimore, MD 21201

OCME

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 05:25 PM 2009 Warren Milledge Tucker 23 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner AGNES HOSPITAL N/A BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Dec 7, 7. Age (In vrs. last birthday) 6 Sex **Funeral** Months Days Hours Min 1920 1 X M 2 □ F Pennsylvania 182-12-1411 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Directo Baltimore Catonsville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA 5741 Edmondson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 No 1942 If Yes, Give Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Clerk is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phyllis Mae Singleton Warren Fuller Tucker ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troone. Linda Tucker KaiKai, daughter 7826 Main Falls Circle Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Metro Crematory Inc. 05/26/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 21. Signature of Funeral Service Licensee Thomas Gregor Thomas 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pertoration disease or condition resulting in death) olonic /Medical Due to (or as a consequence of) Examiner Proctoscop Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury attending physician and for use as the buriaf-tran that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) I □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Ventilator 2 No 1 ☐ Yes espiraton 1 TYes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Ves 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 🔲 Natural 5 Pending UNKNOWN M 1 ☐ Yes 2 No COLONIC PERFORATION DURING PROCEDUR investigation 2 Accident MAY 06,2009 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 900 CATON AVE ST AGNES HOSPITAL BALTIMORE, MD 21229 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAY 23 2009 ABDELMADY, MD and HEIDE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NISHANT MERCHANT BALTIMORE, MD 21229 MD AGNES HOSPITAL 900 CATON AVE 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

			1 - State of Maryland		artment of Health			ene 3. No. 20	09	16748
	_		negistrar     Decedent's Name (First, Middle, Last)				Date of Death	g. 140. —		3. Time of Death
	Physicia		BARBARA ANN TANCEMORE			Ma	Month ay 2	Day 20	Year 09	21:19 M
and of	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location		~1 -	4c. County		
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	a or		804 WINDSTREAM WAY APT D		21040		10	U.S.		y.
	eath	era	11. Marital Status 12. Was Decedent Ever in U.S.	13 \			Yes or No-		e - Americ	an Indian.
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Ž	alth a		Mary E. Little/Mother	503.	l Race St., A	pt 409	, Phila	delphi	a, P	a. 19139
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Ĕ	Pagement ant: I		XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ST.	JAME	S CEMETERY	05-30-	09 H	HAVRE I	E GR	ACE, MD.
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service December	22 W	Name and Address of Facil ILLIAM C BROW 21 S PHILADEL	ility IN COMM	FUNERA	AL HOME	E-HAR	FORD, P.A. D., 21001
			23a. Part I Enter the disease, or complications that caused the death.							Approximate Interval Between
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Multisum Oracle Faul Vivie  Oracle Faul Vivie  Onset and Death  Onset a							
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8760,	cate be executed physician and the burial-transit	dical E	d							
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Вох	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 gnoputs?  1 ☐ Live birth 2 ☐ Fetal de	eath 3	Ectopic pregnancy				te of delive	ery Day Year
0	w requires that the de been signed by the s should be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	th 5L	Other (specify)					
ر. ت.	s that gned t	by Pi	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cause given in Part	t I.	23e. Did toba	acco use cont	ribute to ti	he cause of death?
ğ	equire	pa	Darcoldosis		,		1 ☐ Yes	2 □ No	3 ☐ Prol	pably 4 Unknown
Division of Vital Records,	e law r has be e 2 sh	Completed	Chronic Imunosuf	pp ve	SION		24a. Was an autopsy		prior to co	psy findings available mpletion of cause of
<u>=</u>	the cate by page	Con	Afrial tibrilation,	Hi	pertous ra	on	perform 1 □ Yes 2	No No	death? 1 □ Yes	2 12 No
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7			* /n/ When!	11/2/	1046	1t6		5-21	-07	7
	5 V		30. Name and address of person who completed cause of death (Item 23	3a) (Type,	Print) & Waton	A 1/6	, 4	16	MD	21078
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Spar	V.	,,,,	, , , ,		1	( , )
	Registr		MAY 26 2009 Cerous B.	Agai						

DO, O. May 21 2009, T.O.D

Tancemore, Barbara

lary B. Taggart		State of Maryland / Departr	ment of Health and Mental H		2009 1674				
, 55		1- For State Certifi	icate of Death	Reg.					
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death				
ledical Exami		Mary Beth Taggart		Month D April 30, 200	1430 hrs				
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	h	4c. County of Death				
		783 W. Bel Air Avenue RM 111	Aberdeen	lo p (Blath)	Harford				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to	birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Mir	s. 8. Date of Birth(	Foreign				
Director		221-58-9163 1 M 2XF 47	Yrs.	11/01/	1961 Country) DE				
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tox	wn or Location		10d. Inside City Limits				
<b>*</b> .	L	To Don't	Marana		1 Yes 2 X No				
Aaryland 28a-f show 1 at once.	cto	FL Lee Fort	10f. Zip Code	10g	. Citizen of What Country?				
th the Maryland 23a or 28a-f sho notified at once	Director	2045 Winkley Ave	33196	119	SA				
with th	ral	2845 Winkler Ave 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( S	Specify Yes or No-	14. Race - American Indian, Black,				
death	Funeral	1 Never Married 2 Married Armed Forces?  1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.				
after	by F	3 Widowed 4 X Divorced If Yes, Give Yeer or Dates:	1 Yes 2 X No specify:		Specify: white				
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-00; 1 with giene ther t	Completed	17. Father's Name (First, Middle, Last)	real estate investor	ne (First, Middle, Ma	real estate				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be C	Jack Bodzo	Barbara	Ann John	son				
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other trannatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or						
MD nd 2 sho ulth and m 27 is anmati			111B Congressional Da	r., Green	ville, DE 19801				
Fe, l and l'Heal			ce of Disposition (Name of cemetery, matory or other place)	Date 2	20c. Location - City or Town, State				
Pages ent of		Dullai 2 A Ciernation 5 Removal non State	verbrook Crematory 5/6	6/2009	Wilmington, DE				
Baltimore, MD 21215-00: permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other thingry or other transmatic event, the Med		21. Signature of Funeral Service Licensee MO1139	22. Name and Address of Facility Jo 8521 Loch Raven B Baltimore, MD 2128	hnson Fu	neral Home				
<b>00</b> % % % % % % % % % % % % % % % % % %	S	Heath Hay - Davison	Baltimore, MD 2128	36					
Physician /Medical		73a. Part I. Enter the disease, or emplications that caused the death. Do failure. List only one cause on each line.		or respiratory arrest	Between Onset and				
xaminer	10	Immediate Cause (Final disease a. Methadone intoxication or condition resulting in death)  Due to (or as a consequence of):							
		b backs (or as a sombodes into si).							
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examin	(Disease or injury that initiated events resulting in death) Last							
uted nd ransit		d							
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760, cate by physic he bur	Mec	IF FEMALE: 23c. If yes, outcome of pregnan	ncy		23d. Date of delivery				
68 certifi nding se as t	ian/	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death	2 Fetal death 3 Ectopic pregr	nancy	Month Day Year				
Box 68760 e death certificate b the attending physied for use as the bu	Physician/Med	1 Yes 2 No 9 V Unknown 9 Unknown	5 Other (Specify)						
that the dred by the detached		Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?				
s, P.O. irres that the signed by it is detached	d by			1 Yes	2 No 3 Probably 4 Unknown				
cords law requi has been 2 should	Completed			24a. Was an autopsy					
Recc The lav icate has	mc			perform 1 ✓ Yes 2					
tal Reco cian: The law certificate has	Be C	25. Was case referred to medical	26.Place of Death (Check	k only one)					
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been sed in by the funeral director, page 2 should!	0	examiner?  1 V Yes 2 No Hospital: 1 Inpatient 2 EF	R/Outpatient 3 DOA Other Nurs	sing Home 5 R	esidence 6 🗸 Other: Scene				
ing Ph After t funeral	n: T	1 Notural (Month, Day, Year)	Bb. Time of Injury 28c. Injury at Work?	1 .	w injury occurred				
isior Attend er death rector: by the	ertification:	Pending Fd 4/30/09 Fd	d 2:52 pm Yes 2 X No	unk					
JVIS	reet and Number or Rural Route Number, City ate) 783 W. Bel Air Ave								
To see a second of the second									
g : g : g : g : g : g : g : g : g : g :									
To To con	Мес	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)				
		D. O P.00.	O.C.M.E.		May 1, 2009				
		30. Name and address of person who completed cause of death (Item 23	la)						
7		Patricia Aronica-Pollak MD. Assistant Medical Ex		ore, MD 21201					
C+	ata	31. Date filed (Month, Day Year) 72. Registrar's Signature							

			1 - State of Ma Registrar	aryland		artment of H rtificate of L			giene <sub>Reg. No.</sub> 2	009	16750
İ	Physicia	an	1. Decedent's Name (First, Middle, Last)  George Fulton Tracey					2. Date of Dea Month	Day	Year	3. Time of Death
4.0	/Medic Examin	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or	Location of Deatl			unty of Deat	
)			Saint Joseph Medical Center				Tow				timore
	Funeral Director		214-01-8060 11XM 2□F	e ( <i>In yr</i> s. <i>I</i> as <b>91</b>	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,			_	thplace (State or Foreign ountry)
	and ow	al Director	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary a-f sho		Maryland Baltimore		Lut	herville					1 ⊡Yes ŽŽNo
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Middel Evel. Inc. in ust be notified at or other traumatic event, the Middel Evel. Inc. in ust be notified at		10e. Street and Number 11406 Greenspring Avenue			10f. Zip Code <b>21</b> (	093		10g. Citizen	of What Co	ountry?
	ems 2	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puerl	Specify Yes or No to Rican, etc.)	- 14.	Race - Ame Black, White	erican Indian,
Maryland 21215-0036	ours afte ral", or it Exercito	þ	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ № If Yes, Give Year or Dates:			I∐Yes 2 <b>K</b> No	Specify:	,			White
15-	יח 72 ה "natu	lete	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	rking	16b. Kind	of Business/	Industry
212	l withir giene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5	+)	Cler		"		Railv	vay Ex	press
g	e filed al Hyg I othe went,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,			
Зa	12 should be fi h and Mental P 7 Is marked of raumatic evel	2	George A. Tracey					ie Hasso			
ĭ Za	d 2 sh Ith and Ith and Itaum		19a. Informant's Name/Relationship (Type. Print)  Lillian Tracey Wife			g Address <i>(Street a</i>					Zip Code) MD 21093
Je,	ss 1 and of Health item 27 r other to		20a. Method of Disposition	20b. Plac	ce of Dispo	sition (Name of natory or other plac	i	Date Date			Town, State
altimore,	and her Pa		12D Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Puneral Service Licensee (	Dru	id Ri	dge Cemet	ery 5/26				Maryland
Ba	permit. Departr Importa any Injt		Duym B. Hens	1)	B 3	Name and Address urgee-Her 631 Falls	nss-Seitz Road, E	Funera Baltimore	l Home e, Mar	, Inc	. 21211
		8 /4	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final		Do not ent	er the mode of dyin	ig, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
Lang.	hysician /Medical		disease or condition resulting in death)  CONGE  Due to (or as			RT FAIL	URE				YEARS
	Examiner		ACUTE	ON C	CHRON	IIC RENA	L FAILU	JRE		DAYS	
	nsit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequer	ence of):						
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ν. σ.	iires that i signed by d be deta	by Ph	Part II. Other significant conditions contributing to death b	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contri						contribute to	te to the cause of death?
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/ita	Physician: r this certific ral director,		25. Was case referred to medical examiner?			Loui		ath (Check only c		-	7-0
	Phys	<u>۲</u>	1 Yes 2 Hospital: 1 Inpatie		R/Outpatier	t 3 □ DOA Othe	4 LI Nursing F	lome 5 ☐ Resident			ecify)
on	Attending Physician: ir death. ector: After this certific by the funeral director,	atior	1 Natural 5 Pending (Month, Da 2 Accident investigation		Injury	28c. Injury Work M 1 🗆	(?¯` Yes 2 □ No		,		
Division of	al or Atten s after deat il Director: ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injuding, etc.	ury - At home c. (Specify)	ne, farm, str	eet, factory, office		28f. Location (: City or Tox		umber or R	ural Route Number,
+	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	ledical C	29a. Certifier (Check only one)  Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner steepens.	f examinatio	ledge, death on and/or in	n occurred at the tirvestigation, in my o	me, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) an date and pla	d manner a	s stated. e to the cause(s)
V	To the within 2 To the comple	Me	29b. Signature and time of certified	1		29c. License			29d. Date s	igned (Mont	th, Day, Year)
			30. Name and address of person who completed cause of d	eath (Item 2	23a) (Type,	Print)	<b>db</b> b		1 100	1	7000
	Sta	te.	31. Date filed (Month, Day, Year) 32 Registra	ar's Signatur	SLER re -	-	TOWSON,	MARYL	AND S	1204	
	Registr		MAY 26 2009 Certura	J.	pa	Made					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:57 a<sup>™</sup> Dennis Μ. Thome Mav 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 28 Allegheny Ave. #1601 Towson Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min **TX**□ M 2 □ F 69 Director 216-36-8451 July 29. 1939 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examination and the invitiged at Director Md. Baltimore 1 ☐ Yes 2 ☑ No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 USA 28 Allegheny Ave. #1601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Dentist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Edwin Joseph Thome, Sr. Margaret Kozma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Allegheny Ave. #1601 Towson, Md. 21204 Mrs. Margaret Thome/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iter any injury or ott once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5☐Other (Specintombment Lorraine Park Cemetery 5-27-09 Woodlawn, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Erfler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death andiovascular Immediate Cause (Final Physician 4++611090 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitai or Attending Physician: The law requires that the death certificate be executed buriai-trar Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2XXNo death? 1 □ Yes certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 🗀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. after death Director: 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 🛘 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi 20c. License number 10+11 30. Name and address of perso eted cause of death (Item 23a) C7. Luthaville, Md 21093 Year 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Elspeth Mary Udvarhelyi 2009 11:18 PM May 24, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore | Tif Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov 8, Nov 8, 9. Birthplace (State or Foreign Country)
Scotland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1929 1 ☐ M 2 💢 F 79 213-42-4382 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be nutified at 1 ∑Yes 2 ☐ No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 830 West 40th Street Apt. 654 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married Married o. 1 □Yes 2 🛣 No Specify: White Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Developement Director Theater and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Ada Young Ian McGregor Campbell ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2185 Wyndtree Lane Malvern, PA 19355 27 I. Steve Udvarhelyi, Son permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other: once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/26/09 Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed certificate has been a 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes this 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury After 5 Pending investigation 1 Tyes 2 No after death filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lendale R. Favikaermo/ 555 W. Towsartown Blud/ Balto NO 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Degedent's Name (First, Middle, Lac 2. Date of Death 3. Time of Death **Physician** 010 DERGHE DANNE ANDEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Ginger Cove Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Pay, June 13 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗷 F 473-28-6800 80 Yrs. Minnésota Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, If a Mydical Expriment that indiffed at 1 □ Yes 2 No Director Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 USA 1209 River Crescent Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or White 1 ☐ Yes 🎾 No Specify: ≥ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed permit. Pages 1 and 2 should be filled wir Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic power? Realtor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myra Lucille Hoffman Walter James Terry ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9268 Grantham Drive Mechanicsville, VA 23116 Renee V. Goode, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/25/09 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service License Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can see on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): Examiner -oura Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the use 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ō Dav 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 2 🗆 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the c 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Signature and title of certi 29c. License number who completed cause of death (Item 23a) (Type, F Name and address of pel FENSE HIGHWI

State Registrar

31. Date filed (Month, Day, Year)



09-04117		Please Type or P					ble.	
Cherne-re Woote		State of N For State	Maryland / Depar	rtment of Heal tificate of Deat			200	9 167
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		inouto or zout		Reg. 2. Date of Death	. 3	3. Time of Death
Medical Examin		Cherne	re	Wo	oten	Month D May 23, 200	year 19	1511 hrs
1		4a. Facility Name (if not institution, give street		7.	Town, or Location of Deat	h	4c. County of Death	
_		308 North Carrollton Street		Baltir			NA NA	100
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) If Und Month	er 1 Year   If Under 24Hr	`	Fernian	
Director		217-29-3143 1 M	2 F 18	Yrs.		7-9-1	990 Cour	ntry) MD
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location			i i	10d. Inside City Limits
<b>A</b>	١	MD NA	Bo	altimore	,			1 Yes 2 No
faryla 288-f	Director	10e. Street and Number		10f. Zip	Code	10g	. Citizen of What Count	ry?
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th wit	Funeral		Was Decedent Ever in U.S Armed Forces?		ent of Hispanic Origin? ( S ify Cuban, Mexican, Puert		14. Race - Americ White, etc.	an Indian, Black,
er dea		3 Widowed 4 Divorced If Yes	Yes 2 No	1 Ves 2	No specify:		Specify: Blo	ack
ural"	≙	15. Decedent's Education (Specify only hig	ites:		Occupation (Give kind of	work done 1	6b. Kind of Business/In	dustry
72 hou	e e		College (1-4 or 5+)		orking life. DO NOT use re	tired)	~	
5-0036 led within 7 Hygiene. other than	Completed	Student	NA	Stude			Student	
5-0 iled w Hygie	ပိ	17. Father's Name (First, Middle, Last)	1		18. Mother's Nam	ne (First, Middle, Ma		
2121 buld be fi Mental   marked	a l		ooten	10h Mailing Address	s (Street and Number or	90eline	John State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	٩	19a. Informant's Name/Relationship (Type, I Norman Wood		1010 Po	nnsylvani	^	10	4 Baltimore
and 2 lealth tem 2	ŀ	20a. Method of Disposition	20b. F	Place of Disposition (Na	me of cemetery,		20c. Location - City or T	
Baltimore, permit. Pages I an Department of He- Important: If ite		1 Surial 2 Cremation 3 R	emoval morn state	rematory or other place	· /	30-09	Baltines	× 110
Baltimo Permit. Pag Department Important:	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		22.(Name and		50 0 1	baltimor	Bolt roce
Balt permit. Departi Import injury		Make new		Wylie	Funeral Hom	PA 63	& Gilnore St	MD 21217
Physician	$\neg$	3a. Part I. Enter the disease, or complication failure. List only one cause on each lin	ons that caused the death.	Do not enter the mode	of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
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1760, ficate be exe g physician a the burial -			c. If yes, outcome of pregr	nancy			23d. Date of delivery	
687 ertific ding p	au/	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of de	2 Fetal death		nancy	Month D	ay Year
. Box 68760, he death certificate be the attending physic hed for use as the burn	Physicia	1 Yes 2 No 9 V Unknown g		other (Sp	ecify)			
O. E at the d by the detached	됩	Part II. Other significant conditions cont	ributing to death but not re	esulting in the underlyin	ig cause given in Part I.		acco use contribute to	
cords, P.O. law requires that th has been signed by 2 should be detach	함					1 Yes	2 V No 3 Prob	ably 4 Unknown
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Vital Recysician: The Inspecting the Inspection of the Inspection	ပ္ပို	25. Was case referred to medical	-		26.Place of Death (Chec			
Vita hysicia this ce	8	examiner? 1 ✓ Yes 2 No	al: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nurs		Residence 6 V Other	: Scene
Division of Vital Records, tat or Attending Physician: The law requirers after death.  "al Director: After this certificate has been sled in by the funeral director, page 2 should be	ᆵ	27 Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho Subject shot	ow injury occurred	<del></del>
ion trendi leath. tor: ,	s	2 Accident Investigation	May 23, 2009	FOUND: 1450 hrs	1 Yes 2 ✔ No	,		
ivis for A after o Direc	Certification:	Suicide Could not be	28e. Place of Injury - At ho		ry, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Ru ate) olton Street, Baltimo	ral Route Number, City
Dospital hours meral y filled	Š	4 V Homicide determined	(Specify) Rowhouse			1	-	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	edical	(Check only one) 2 Medical Examiner: On the control of the control on the control of the control	o the best of my knowleds	ge, death occurred at tr nd/or investigation, in n	ne time, date and piace, a ny opinion, death occurre	nd due to the cause d at the time, date a	nd place, and due to th	e cause(s)
To To Com	Se l	29b. Signature and title of ceptifier	nanner_stated.	29	9c. License number		29d. Date signed (Moi	nth, Day, Year)
31		/ // /			O.C.M.E.		May 24, 2009	
	-	30. Name and address of person who comp	leted cause of death (Item	23a)				
OCME	_		Chief Medical Exar		Street, Baltimore,	MD 21201		
Sta		31. Date filed (Month, Day, Year) <b>NAY 2 6 2009</b>	32. Registrar's Signatu					
Registr	αľ	MAT & 0 2009	Skreua a.	parker	<del></del>			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. laryland / Department of Health and Mental Hygiene Certificate of Death State Registrar 1. Decedent's Name (First, Middle, Last) Elizabeth Ann Wilhelm 2. Date of Death 3. Time of Death **Physician** Month Day Year Elizibeth Ann Wilhelm 12; 30 PM /Medical 2  $300^{\circ}$ 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore n/a 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 □ M 2 🕶 F Hours Min. 219-42-7624 Director 66 3-28-1943 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified as 10d. Inside City Limits Directo 1 ☐ Yes 2 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 Frock Drive 21157 Funeral United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☒ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Administra<u>t</u>ion\_Ass<u>is</u>tant Finch Services 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John E1mo ၉ Dorothy L. Blizzard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose M. Garin (sister) 4302 Crab Orchid Rd. Glen Arm, MD 21057 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/27/2009 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Mt. Gilead Cemetery 5 26 2009 Reisterstown, MD 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee leer suns |11824 Reisterstown Rd. Reisterstown, Md 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Preumonia Onset and Death **Physician** days /Medical Due to (or as a consequence of): Examiner Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Metastatic Smal Due to (or as a consequence of): and -tran Small Cell concer of the Lung burial-t physician the burial O. Box 68760. Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 1 ☐Yes 2 No 5 ☐ Other (specify) 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 1 X Yes 2 🗆 No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director; A 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21,2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaymond Memorial Inion 31. Date filed (Month, Day, Year) State 82. Registrar's Signature Registrar MAY 2 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Evelyn Whitman 9:10 AM 2000 2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner BAITIMORE If Under 1 Year | If Under 24 H 9. Birthplace (State or Foreign 5. Social Security Numbe 213–20–7519 (In ws. last birthday 8. Date of Birth **Funeral** Months Days Hours Min. 02/09/1926 1 □ M 2 🔀 F 83 MaryTand **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Nectical Examinar must be notified at 1X Yes 2 □ No Maryland | N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Hygiene. 21224 U.S.A. 3422 E. Pratt Street Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Physician's Assistant Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Archibald McAllister Mollie Keller ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau 3422 E. Pratt Street Baltimore MD 21224 Joseph A. Cerra Companion Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 → Burial 2 □ Cremation 3 □ Removal from State 05-26-2009 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville MD 21228 21. Sun ture of Funeral Service Licens Demo Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of emplications that caused the death. Do not anter the mode of gying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) days **Physician** /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading commodities cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) law requires that the death certificate be executed Exami and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? ned by the atter detached for u 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown icate has been signed by ...page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 0 1 Tes 2 No 3 Probably 4 Unknown Completed 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 1 ☐Yes 2. No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director; 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide To the Hospital or 1 🖃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

whitmar

31. Date filed (Month, Day, Year)

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh g891 5-28-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 3 Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day 2009 **Physician** Julia Zimecki 5:00a<sup>M</sup> 23, May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Hospice of the Chesapeake If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/28/1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 103-12-3054 1 □ M 2 □X 88 NY Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant if Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at Lanham 1 Yes 2 □ No MD Prince George' Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 USA 9885 Greenbelt Road, Apt. 311 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed r than "natur the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Publishing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pelles Michael Dic Martha ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cheverly Circle, Cheverly, MD 20785 Friar / Daughter Gloria 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. Ardent 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/25/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD ke of Funeral Service Lice see Orota Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dern **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate has performe 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Certification: To Be 6 Domer (Spec Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient WUSE funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) Signature and title of certifier DEFENSE HIGHWAY ANNAPOUS MD 21401 who completed cause of death (Item 23a) (Type, Prim 445 W 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar General

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8<sup>Day</sup> 3. Time of Death Month 5 2009 Christian Paul Addicks 1:00 p <sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 4/14/1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 🛛 M 2 🗆 F Months 82 216-20-7257 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XYes 2 No Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21842 USA 231 S. Ocean Drive 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 MaYes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter Emergency Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christian Addicks Mary Ann Schuh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 231 S. Ocean Drive, Ocean City, MD 21842 Cecilia Addicks / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 5/11/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Burbage Funeral Home Berlin, MD 21811 108 William St., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ineart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 Immediate Cause (Final disease or condition resulting in death) Years sequence of) Cers. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🛂 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 PHnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

**Physician** /Medical Examiner P.O. Box 68760

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Division C

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**Physician** 

/Medical

Examiner

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Medical Certification: To

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**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, ID-3 Mp. 2006.

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

burial-trar signed by the attending physician I be detached for use as the buria has been s certificate has I lirector, page 2 s

The law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

BA 4+1

State Registrar 29a. Certifier (Check only one)

3 Suicide

4 Homicide

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9/09

Name and address of person who completed cause of death (Item 23a) (Type, Print)

)ellelog 31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

32. Registrar's Signature

tal Hylmy Furnate Island, De

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 16759

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Physicia		Registrar  1. Decedent's Name (First, Middle,La	ast)					2.	Date of Deat Month		ear	3. Time of Death
edical Exami	٠	Alima Faitmah A							May 4, 200	)9		1100 hrs
		4a. Facility Name (if not institution, g	ive street and numbe	er)	41	o. City, Town, o		Death		4c. Count	y of Death George	
. )		Temple Hills Rd & Salina				Temple Hi		- 411	O. Dto. of Diss		•	thplace (State or Foreign
Funeral		Social Security Number     6.	Sex 7. A	Age (In yrs. last bi		If Under 1 Ye	-	Min.	06/11		Cc	DC
Director		220-02-0949	M 2X F	25	Yrs.				00/11	1905		
		Usual Residence of Decedent		10c. City, Tow	n or Locatio	<u> </u>						10d. Inside City Limits
w any		10a. State 10b. County	Cooreola	Clint		<b>7</b> 11						1 X Yes 2 No
Maryland 28a-f show any d at once.	ō		George's	CITIIC	.011	10f, Zip Code				og. Citizen of	What Cou	intry?
Mary 28a-	Director	10e. Street and Number	-				735			_	JSA	
eath with the Maryland or items 23a or 28a-f sho must be notified at once.		9634 Gwynndale			40.10/04	Decedent of F		in? (Sne	cify Yes or No			rican Indian, Black,
h wit ems 2 t be n	Funeral	11. Marital Status  1 X Never Married 2 Marri	12. Was Decede		If Ye	es, specify Cub	an, Mexican	Puerto R	ican, etc.)		hite, etc.	
	표		1 Yes	2 X No		Yes 2 X M	lo specify:			Specif	fy: B1	ack
s afte iral", miner	ğ	3 Widowed 4 Divorce  15. Decedent's Education (Specify	or Dates:	completed) 16a	a. Decedent	's Usual Occup	oation (Give	kind of wo	ork done	16b. Kind of	Business	/Industry
hour "natt	ted	Elementary/Secondary (0-12)	College (1-4		during mo	ost of working li	ife. DO NOT	use retire	ed)			]
36 hin 73 than than	혈	12		С	ashie	r				Groce		tore
d wit ygien ygien other	Completed	17. Father's Name (First, Middle, La	ist)				18.Mother	's Name (	First, Middle,	Maiden Surna	me)	
21215-0036 July be filed within 72 hours after death with the Maryland Ahenla Hygiens hand "matural", or items 23a or 28a-f sho re event, the Medical Examiner must be notified at once	Be (	Willie Allen I	II				Pame	<u>la K</u>	. Seymo	our	~ 0:	- 7 · Codo)
D 21 should I and Mer 7 is man	ြို	19a. Informant's Name/Relationship				Address (St						te, Zip Code)
ore, MD es 1 and 2 sho of Health and If item 27 is ther traumati		Pamela Allen/M	<u>other</u>			Gwynnda ition (Name of		., <u>C</u>	Linton, Date	20c. Locati	on - City (	or Town, State
Fe, slan fitter Fiter		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from		atory or oth	ner place)	00111010191					
Page nent c		4 Donation 5 Other Spec	eify:	Linc		emorial			11/09			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Menfal Hygieral Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Sign ture of Funeral Service Li	ensee	11								ervices
		23a, Part I. Enter the disease, or co	ull y	and the death. Do	not enter t	DU ALLE	entown	RO.	respiratory ar	rest, shock, or	r heart	ID 20748 Approximate Interval
Physician (Medical		failure. List only one cause or	each line.									Between Onset and Death
amine		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Blun Due to (or as a co		es							
» /			b.	onsequence or,								
	펄	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):								
	Examiner	(Disease or injury that initiated	C. Due to (or as a co	onsequence of):								
scuted and transit		events resulting in death) Last	d.	,								
al ex	1 33	UNPENDED	AMENDED									
760, cate be ex physician	Pe	IF FEMALE:	23c. If yes, ou	tcome of pregnan	icy						te of deliv	
587 ertifica ling p		23b. Was decedent pregnant in the past 12 months?	1 Live birt		_		3 Ector	ic pregna	ncy	Mon	th	Day Year
Box 68: e death certificates the attending	sician/	1 Yes 2 No 9 V Unkn	7	nt at time of death	5 O	ther (Specify)						
D. B. trithe de by the ached of	3   3	Part II. Other significant condition			Iting in the	underlying cau	se given in f	Part I.				to the cause of death?
ires that the signed by	۾								1 _ Y	es 2 🗸 No	3P	Probably 4 Unknown
ords, w requires us been sig	t d								24a. Wa	s an 2	24b. Were	autopsy findings available to completion of cause of
COFC law re has be		L							per	formed?	death	1?
tal Rection: The certificate	Completed					26 🗆	lace of Deat	h (Check		3 Z NO		103 2 113
Vital Rec ysician: The l his certificate l	8		Hospital:	patient 2 EF	R/Outpatier		Other:		ng Home 5	Residence	6 <b>V</b> O	ther: Scene
of Vital Records, ig Physician: The law requir ther this certificate has been in many of should it.			28a. Date o		8b. Time of		Injury at Wo		28d. Describ	e how injury o	ccurred	
n of ding Ph	5	1 Natural 5 Pendi	May 4 20	Day Year) 109 1	054 hrs	1	Yes 2	<b>∕</b> No	Driver aut	o auto colli	ision	
Sio Atten r deat ector	1	2 🗸 Accident Invest	igation 28e. Place	of Injury - At hom-	e, farm, str	eet, factory, off	ice building,	etc.			Number or	Rural Route Number, City
Division tall or Attendius after death.	Certification	3 Suicide 6 Could determ	not be	Major Road /					or Town Temple Hill	, State) s Rd & Salir	na Street	, Clinton, MD
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	>	1 /9a Certifier	-i-len. To the best	of my knowledge	death occ	urred at the tim	e, date and	place, and	d due to the ca	ause(s) and m	anner as	stated.
the F the F	Modical	(Check only one) 2 Medical Exam	niner: On the basis of	examination and	or investig	ation, in my op	inion, death	occurred	at the time, da	te and place,	and due t	to the cause(s)
To To	N	29b. Signature and title of certifier				29c. Li	cense numb	er		29d. Date	e signed	(Month, Day, Year)
2		Mula	1	MD		0	.C.M.E.			May 5	, 2009	
"\		30. Name and address of person	who completed cause	e of death (Item 2	3a)							
D		Russell Alexander MD		edical Examir		1 Penn Str	eet, Baltir	nore, N	1D 21201			
0401	Stat	a 31. Date filed (Month, Day, Year)	32. Res	gistrar's Signature	wes							
	istra	MAY 1 2 2009	( leaven	A. A.	~						111.11	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20000

			for State Registrar	Oldio of W	ai yiaiia		tificate of I			Reg. No.	2009	10100
	Physici	on	1. Decedent's Name (First, Mide						2. Date of De		Year	3. Time of Death
	/Medic		Gary						May	Day 6	2009	4:15 P M
	Examin	er	4a. Facility Name (If not instituti	ion, give street and number) Memorial Host			4b. City, Town, or	·Location of Deat ederick	h		County of Death	₹
	Funeral		5. Social Security Number		je (in yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs	. 8. Date of Bir (Month, Da		9. Birthpl	ace (State or Foreign
н	Director		219-60-3907	1 <b>∑</b> M 2□F	56	Yrs.	Months Days	Hours Min.	Aug. 2,	1952	Mary1	**
	pu ,		Usual Residence of Decedent  10a. State 10b. Count			Town or Loc						Od. Inside City Limits
	shov shov	'n		,								1 ☑ Yes 2 ☐ No
	the M	Director	MD Wash	ington	над	ersto	WII 10f. Zip Code			10a. Citiza	en of What Count	
	3a or		160 W. Washing	ston St. Ant	1		21740			9	U.S.A.	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba		Specify Yes or No		4. Race - America	
36	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23a or 28a-f show event, its friedical Exp. oils or must be in diffed at		1 ₺ Never Married 2 ☐ Ma	If Yes, Give	No		r Yes, specily Cuba I∐Yes 2⊠No	Specify:	to Alcan, etc.)		Black, White, e	
Ö	hours tural"	ed by	3 Widowed 4 Divorce		-	16a Deced	ient's Usual Occup	ation			WIN d of Business/Ind	ite
15	in 72 n "na l'edic	Completed	(Specify only high	ent's Education nest grade completed)	F.)	(Give I	kind of work done of NOT use retired	during most of wo	rking	l ob. rain	u 01 240111000/1110	dony
212	should be filed within nd Mental Hygiene. marked other than matic event, II. III.	ΕO	Elementary/Secondary (0-12)	) College (1-4or	D+)	Truc	k Driver			Pap	per Comp	any
9	e file at Hy d othe	Be	17. Father's Name (First, Middle					18. Mother's Na	me (First, Middle,	, Maiden S	Gurname)	
yla	2 should be f h and Mental I r Is marked of raumatic eve	P	Warren D. Bake						V. Snyd			
Mar	12sh hand 7Ism traum		19a. Informant's Name/Relation Warren D. Baker		_		g Address <i>(Street</i> efferson					Code)
e,	ges 1 and 2 should in of Health and Men if item 27 is marke or other traumatic.		20a. Method of Disposition	, or , protile			sition (Name of natory or other place		Date		21740 ation - City or To	wn, State
ē	Pages nent of int: If its iry or o		'	n 3 ☐ Removal from State	l l		natory or other place n Cemete	i i	/2000	Ungo	rstown,	WD.
Baltimore, Maryland 21215-0036	+ F # =		21. Signature of Funeral Service		ACS (		. Name and Addre					
Ď	permi Depar Impor any ir		> S. Mark	Sings			01 Penns					_
			23a. Part 1. Enter the disease, shock, or heart failure. Li	or complications that cause ist only one cause on each li	d the death. ne.	Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	_a C	ONC	101	Lemo	an	yth	MLC	X A	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):	Q	most!	2224	MIN	11.00	1 Years
		ē	Sequentially list conditions,	b. Due to (or as	a conseque	nce of):	ea	111	rrye	011	Hmsele	201%
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 COC	ne	126	at	neve	28 ClE	W Do	W	
ó	e exec an an rial-tra	Еха	resulting in death) Last	Due to (or as	a conseque	ence of):						
68760,	rtificate be executed ng physician and as the burial-transit	Medical		d								
			IF FEMALE:	00-16								
X B B	eath c attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1  Live birth 4  Pregnant	2 Fetal d	ieath 3 □	Ectopic pregnanc	у		23	3d. Date of delive Month	ery Day Year
o.	the d	Physician/	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	at time or dea	uii	Jotner (specify) _					
~, o,	law requires that the death ce as been signed by the attendi 2 should be detached for use	by Pł	Part II. Other significant condi	tions contributing to death b	out not result	ing in the un	derlying cause giv	en in Part).	23e. Did t	tobacco us	e contribute to th	ne cause of death?
ğ	en sig		Chrowe	011818	NOT	We.	MILS	Clou	JUK 10	Yes 2□	No 3□ Prob	ably 4 Unknown
Vital Records,	law re as be 2 sho	Completed	anbet	es scu	120	Ive	na	-	24a. Was		24b. Were autop	psy findings available
<u>~</u>	: The lav	Com		1	,				perfo 1 □Yes	rmed?	death? 1 ∐Yes	mpletion of cause of
<u>₹</u>	ysiclan: The lav lis certificate has director, page 2	Be	25. Was case referred to medic examiner?	Hospital:			4 a 🗆 Boa   Oth	or: A	ath Check only o			
6	Attending Physiclan: r death. ector: After this certific by the funeral director, I	L.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpati 28a. Date of Inji		R/Outpatien 28b. Time of	1 3 DOA	4 Nursing i	Home 5 ☐ Resi 28d. Describe		Other (Specify	<i>)</i>
0	nding th. : After	tion	1 Natural 5 ☐ Pend		ay, Year)	Injury	Wor	k? Yes 2∐No	EGG. Describe	now injury	occurred	
Division	Atter er dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could	rmined   28e. Place of In	jury - At hom tc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (	Street and wn, State)	Number or Rura	I Route Number,
5	tal or rs afte al Dir led in	Certification:	4   Homolde	building, e	ис. (ороспу)				Ony or ro	wii, Olalej		
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	edical		ying Physician: To the best al Examiner: On the basis	of examination							
	o the ithin 2 o the omple	Med	29b. Signature and title of certif	and mariner st	lated.		29c. Licens	e number	00	29d, Date	signed (Month,	Day, Year)
	F S F Ö		> Walne	+ KWXM	100		D	065	88	W	PXth	2007
,			30. Name and address of perso	who completed cause of	death (Hem 2	23a) (Type, F	Plint)	1 7	113	cot	+CH.	1
2	H-1		MELVIN KOK	NON MI)	9501	1010	HAMPIN	elis Ko	W	lary	land	21004
	Sta Registr	_	31. Date filed (Month, Day, Yea	1 2009 June	rar's Signatu	A. A.	arkel			, ,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 28,2009 3:12P M MONTEZ Η. BOATMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atrium Classic Home Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April | April | Birthplace (State or Foreign Country)
 NC 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 5,1922 1- M 2 F 246-09-0455 87 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Silver Spring MD Montgomery 1X Yes 2 □ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 U.S.A. 133 Ritchie Ave Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2★ No Black Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Worker DC Government 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Gray Farmer Hooker Betty Florence Caddell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 1948 Flowering Tree Terr Silver Spring, MD 19a. Informant's Name/Relationship (Type. Print) nt of Health a If Item 27 is or other trai Cedric L. Boatman- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any Injury or once. Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 5/9/09 | ROCKVIIIE, FID Snowden Funeral Home, PA Parklawn Mem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 246 N. Washington ST Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bursal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I PARKINSONS DISEASE HISTORY OF STROKE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed HISTORY OF COLON CANCER 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number n m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 6525 Belcrest Rd #160 Hyattsville, MD 20782 Teresa E. Allen, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 7, Year **Physician** 2009 Sanford L. Berman 10:55 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Arcola Nursing Home Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/22/1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1 3 tM 2 □ F 090-20-1080 82 New York Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylan show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 808 Malta Lane 20901 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 X2Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 X No Specify Specify: <u>≨</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) Microbiologist U.S. Government s 1 and 2 should be filed with Health and Mental Hygier Item 27 is marked other the permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hyman Berman Jeanette Lebow ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Berman, wife 808 Malta Lane, Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 05/10/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. Gonald L. Hottlemus M00564 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that y used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Cerebrovascular Accident 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) burialattending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Hlnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1□Yes 2KINo 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. I hours after death 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D34032 May 8, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeanne P. Asher, MD 3720 Farragut Avenue, Kensington, Maryland 31 Date filed (Month,

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 9

			1 - State Registrar		Cer	tificate of l	Death	F	Reg. No.		0,00	
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea		3. T	ime of Death	
	Physici /Medic		Joan K	athryn Bowers				May 8	Day 200		47 A M	
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Deat		4c. County			
			4922 Edmondson Ci	reek Road		Prest				roline		
	Funeral		5. Social Security Number 6. S	ПМ 2-П =	ast birthday)_ Yrs.	if Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	r, Year)	Country)	State or Foreign	
à.	Director		212-30-2067 Usual Residence of Decedent	74	113.			Nov.13,	1934	Maryla	ind	_
	land ow		10a. State 10b. County	10c. City	, Town or Loc	ation				10d. In:	side City Limits	-
	Mary -f sh	호	Maryland Carol	line P	reston					1 [	□Yes 🔭 🗆 No	
	r 28a	Sec.	10e. Street and Number	THE 1	TESCOII	10f. Zip Code			10g. Citizen of	What Country?		+
	h with	Funeral Director	4922 Edmondson Ci	reek Road		21	655	II	nited S	tates of	Americ	ำล
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. W			Specify Yes or No- to Rican, etc.)		ce - American Ind		
0	after or ite mine		1 ☐ Never Married 2 ☑ Married	1 Tyes 2 No		☐ Yes 2 No	Specify:	to nican, etc.)		ck, White, etc.		
0000	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Hygiene. marked other than "natural" or items 23a or 28a-f show marked other than "natural" or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		LI TOS ERSINO	opecity.		Specif	y: Caucas	sian	
ה	72 h "natu dica	Completed	15. Decedent's Ed (Specify only highest gra	lucation ade completed)	16a. Decede (Give k	ent's Usual Occup ind of work done o O NOT use retired	ation during most of wo	orking	16b. Kind of B	usiness/Industry		
7	within ene. than	ם	Elementary/Secondary (0-12)	College (1-4or 5+)			ับบา	rector	Educat	ion/Food	Servic	٥
7	Hygie Hygie Ifher i		17, Father's Name (First, Middle, Last,		Secr	etary/I		wice   me (First, Middle,			Delvie	_
	d be	Be c	, , , , , ,							110)		j
5	2 should and Men Is marke aumatic	မ	Robert Milton 19a. Informant's Name/Relationship (		19h Mailine	Address (Street		lian Sull		State Zin Code	.)	-
U			Edgar Scott Bower	• •	1			Road, Pr			•	
υ	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Memtal Hygiene 1 feet 23 or 28a-f show feet 71 s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		L	ition (Name of atory or other place		Date		- City or Town, S		-
2	Pages nent of lint: If its iny or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Themoval from State		emetery	1	14,2009	Dento	n, Maryl	land	
	고문원물	1	21. Signature of Juneral Service Lice	, DC	22.	Name and Addres	ss of Facility					-
ŏ	Depar Depar Impor any Ir	9.7	Kamabet	(hoce	M 1	oore Fun	eral Hom	e, P.A. <sub>D</sub>	enton.	Maryland	1 21629	
39			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	. Do not ente	r the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Appr	oximate val Between	
F	Physician	0 1	Immediate Cause (Final disease or condition	1	ncer					Onse	et and Death	
ti.	/Medical		resulting in death)	a. Due to (or a consequ								
B	Examiner		Sequentially list conditions,	b								
	sit sd	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or, injury that initiated events	Due to (or as a consequ	ence of):							
	ecuti and I-tran	хап	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):							_
o .	be ey ician buria			5 do 10 (01 do 11 001100qu	01100 017.							
00/00	ne death certificate be executed the attending physician and hed for use as the burial-transit	Medical		⊾d								-
4	certii nding Ise a		iF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnar	псу				23d Da	ite of delivery		
0	death atter	ciar	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2□Fetal 4□Pregnant at time of de		Ectopic pregnancy Other (specify)	'		1	onth Day	Year	
į .	the c by the achec	Physician	9 Unknown	9□Unknown								
, L	Attending Physician: The law requires that the discast. rector: After this certificate has been signed by the by the funeral director, page 2 should be detached	by P	Part II. Other significant conditions of	ontributing to death but not resul	Iting in the une	derlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to the cau	se of death?	
COLUS,	en sig	pa p						1 □ Y	'es 2□ No	3 Probably	4 ∐Unknown	
5	aw re	plet						24a. Was a	an 24b.	Were autopsy fir	ndings available	
<u>.</u>	The I	Completed						autop perfor	rmed?	prior to completic death? 1 Yes 2 1		
<u>ק</u>	lan: rtiffica stor, p	Be C	25. Was case referred to medical				26. Place of De	ath (Check only of		10163 201	10	-
>	nysic nis ce direc	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2   E	R/Outpatient	3□ DOA Oth	er: 4 \sum Nursing 1	Home 52 Resid	lence 6 DOth	ner (Specify)		
) =	ng Pl fter th neral		27. Manned of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Worl	y at k?	28d. Describe h	ow injury occur	red		
2 3	eath. or: A	atic	2 ☐ Accident investigation			M 1 🗆	Yes 2 □ No					
2	or At ter d irect n by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (S City or Tow	itreet and Numl n, State)	ber or Rural Rout	te Number,	
ם ב	prtal ours at sral c	-		7-1-7-11-1-1-1-1	7-1 1							4
:	Hos 24 ho Fun stely f	edical	29a, Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my know niner: On the basis of examinati and manner stated.	viedge, death ion and/or inv	occurred at the tir estigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place,	anner as stated. and due to the c	cause(s)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signe	ed (Month, Day,	Year)	-
	⊢≯⊢ŏ		1		MD	Do	05325		5/12	1200	,	
			30. Name and address of person who	completed cause of death (Item	23a) (Type, P				110	1000	1	4
			Melinda Butler.		, ,		ston. Ma	rvland	21655			
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure de	41						

Division or Vital Records, P.O. Box 68760,

9 Unknown		3 DOTKHOWN					
Part II. Other significant conditi	ons con	tributing to death but not resi	ulting in the underlying	g cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Honknown	
					24a. Was an autopsy performed? 1  Yes 2  □		
25. Was case referred to medica	ıl			26. Place of De	ath (Check only one)		
examiner?  1 Yes 2 No	Н	ospital: 1 Inpatient 2 🗆	]ER/Outpatient 3□ I	Home 5 ☐ Residence	e 5 ☐ Residence 6 ☐ Other (Specify)		
27. Manner of Death  1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could detern		28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fact	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
		Ician: To the best of my knower: On the basis of examination				(s) and manner as stated. and place, and due to the cause(s)	

29c. License number

DS 3111

29d. Date signed (Mgnth, Day, Year)

Registrar

29b. Signature

and title of certifier

Davis 31. Date filed (Month, Day, Year)

mo of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

2001 Medical Parkway Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Trem 23a per phys (8937/13/09 dk
State of Maryland Department of Health and Mental Hygiene) (1) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician BETTY JEANNE BOSMYER MAY 7 2009 5:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🔀 577-24-0397 Director 12/6/1922 Michigan 86 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f sh 1 ☑ Yes 2 ☐ No Directo MD Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. "natural", or items 23a or 20782 U.S.A. 5613 Jamestown Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔀 No Yes. Give ò Specify. 3 X Widowed 4 ☐ Divorced White Year or Dates: Completed 7 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Dion Ida Beaudin ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau 5613 Jamestown Road, Hyattsville, MD 20782 Cheryl A. Nichols / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 5/12/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final

**Physician** /Medical Examiner

Division of Vital Records, P.O. Box 68760,

After this certificate has been signed by the funeral director, page 2 should be detached

disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit

1 ☐ Yes 2 ☐XNo

	cause on each line.	'		Between nd Death
а.	RENAL FAILURE			
	Due to (or as a consequence of):			
h	Probable Dehydration from prior bout w/C	OPD		
υ	Due to (or as a consequence of):			-
C				
	Due to (or as a consequence of):			
d				
_		1		
23c.	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of de Month	elivery Day	Year

Examine Physician/Medical IF FFMALE: 23b. Was decedent pregnant in the past 12 months? Pa by Medical Certification: To Be Completed

9 LI ONKNOWN	
art II. Other significant condition	contributing to death but not resulting in the underlying cause given in Part

23e. Did tobacco use contribute to the cause of death?
1 ☐ Yes 27 No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 □ Yes 2 ₩ O

		1 □ Yes 2 ☑ No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Death (Check only one)
1 ☐ Yes 2 ∏X No	Hospital: 1  ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify)
27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	M	Injury at Work? 28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ice 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a Certifier 1 CertifyIng Phy	vsician. To the best of my knowledge, death occurred at the	he time date and place, and due to the cause(s) and manner as stated

29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.		
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
+ timeth Dullia	156582 (MA)	05/08/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar TIMOTHY WHITMAN LCDR MC USN 32. Regis rar's Signature

3

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mar		rtificate of			eg. No.	109	16	166
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dear	th 2009	Year	3. Time of 1:50	Death PM
	/Medic	al	ALBERT BRUNOT  4a. Facility Name (If not institution, give s	ctroot and number)		4h City Town o	r Location of Death			ty of Death		PW
	Examin	er	Springbrook Advent:		g Center	Silver S				tgome		
	Funeral Director		Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 09-15-1	Year) 918	9. Birth Cou Hait	place (State ontry) 1,W. I	or Foreign ndies
	and w		Usual Residence of Decedent  10a. State 10b. County	1	10c. City, Town or Lo	ocation					10d. Inside C	ity Limits
	Maryll	tor	Maryland Montgome	ry	Silver S	pring					1 🗗 Yes	2 🗌 No
	th the or 28a e noti	Director	10e. Street and Number			10f. Zip Code 20904		1	0g. Citizen of		ntry?	
	ath wi s 23a nust b	eral I	12325 New Hampshir		. 110		F	'6- Va Na	U.S.	A.	nen Indian	
036	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show do other than "natural", or items 24a or 28a-f show event, the Marical Examiner must be notified at	by Funeral	11, Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1	er in U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity res or No- Rican, etc.)		ack, White,	etc.	
2-0	72 ho 'natur	eted	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occup	oation during most of work d)	king	16b. Kind of	Business/In	ndustry	
121	within ene. than "	Completed by	Elementary/Secondary (0-12) Unk	College (1-4or 5+)		DO NOT use retire: Janitor	d) -	F	rivate	Indu	ıstry	
2	filed Il Hygi other	Be Co	17. Father's Name (First, Middle, Last)		1		18. Mother's Nam	e (First, Middle, i	Maiden Surna	ıme)		II1-
ylar		To B				Unk						Unk
2	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty, Claudia John/guard		19b. Mail 6420	ng Address (Street Allentow	and Number or Ru n Road C					747
ш	permit. Pages 1 Department of He Important: If iten any Injury or oth		20a. Method of Disposition 1 □ Burial 2 1 Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Riverdate	mater or Cherola	itory : 05-1	L	20c. Location iverda	•	•	d
Rail	permit Depart Import any In once.		21. Signature of Funeral Service License  Mary Healyn	ran 137	4 C		FH 4111			and, l		
	Physician		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the cause on each line. Acute Myo				or respiratory arr	rest,		Approximation Interval Be Onset and 1 Hour	Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						2 week	
		ē.	Sequentially list conditions,	Systemic	consequence of):						Z Week	
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	` :								
68760,	tificate be executed g physician and as the burial-transit	sal Ex	resulting in death) Last	Due to (or as a	consequence of):							
	± 0, ∞	Aedical	JE SEMME									
O. Box	he death certific the attending p thed for use as f	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	<b>Э</b>			ate of delivery		Year
ds, P.	res ti iigne be d	þ	Part II. Other significant conditions cor	ntributing to death but	not resulting in the u	ınderlying cause giv	en in Part I.		bacco use co			death? Unknown
Records,	w requ	Completed						24a. Was a			opsy findings	
	The law cate has t page 2 sl	фшо						autop: perfor 1 □ Yes	med?	prior to codeath? 1 ☐ Yes	ompletion of a	cause of
	ician: The law certificate has ector, page 2 s	BeC	25. Was case referred to medical examiner?			· · · · · · · · · · · · · · · · · · ·		th Check only or				
6	hys dir	၉	1 Yes 2 No F	lospital: 1 ☐ Inpatien 28a. Date of Injury	t 2 ER/Outpatie	nt 3 □ DOA		ome 5 ☐ Resid			rify)	
0	nding tth. :: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day,		Woi	k? ]Yes 2 □No	204. 200020	on injury ood			
DIVISION	ipital or Attend	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Nur n, State)	nber or Ru	ral Route Nur	mber,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	edical C	29a. Certifier (Check only one) 1 CertifyIng Physical CartifyIng P	sician: To the best of ner: On the basis of a and manner state	examination and/or i	th occurred at the t nvestigation, in my	ime, date and place opinion, death occu	e, and due to the our	cause(s) and date and plac	manner as e, and due	stated. to the cause(	(s)
	Vithii To th Comp	Me	29b. Signature and title of certifier	14400		29c. Licens		- 1	29d. Date sign		, Day, Year)	
	1-			rafir		D178	74		05-08-	-2009		
	BÌ		30. Name and address of person who co Sankaran Nayar, MD	ompleted cause of dea 3717 38t	ath (Item 23a) (Type h Avenue	Print) Brent	wood, Ma	ryland 2	0722			
Н	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year  $A^{M}$ 2009 9:30 May 1, Nathaniel TT Brown, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7626 Allen Dale Circle Capitol Heights Prince George's 8. Date of Birth F(Month, Day) Year) 940 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Washington, DC 69 1 ☑ M 2 ☐ F 579-50-1097 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 ☐ No Capitol Heights Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7626 Allen Dale Circle 20785 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc.
African 1 Never Married 2 X Married 1 ☐ Yes 2 👿 No Specify 3 ☐ Widowed 4 ☐ Divorced American 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Private Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nathaniel R. Brown, Sr. Alma Reed 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20743 1002 Ouiet View Drive Capitol Heights, MD Ruth E. Brown - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cemetery May 7, 2009 Suitland, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signal of Funeral Service 4001 Benning Road, NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myelogenous Leukemia 1 year Due to (or as a consequence of): Myelodysplastic Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

**Examiner** 

**Funeral** 

Director

show

ir than "natural", or items 23a or 28a-f show the Wedical Examiner in ust be notified at

Directo

Funeral

Completed by

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Pages 1 and 2 should be filed within 72 hours after death

and Mental Hygiene.

of Health and Menta item 27 is marked r other traumatic ev

permit. Pages 1
Department of F
Important: If ite
any injury or ott

Baltimore, Maryland 21215-0036

/Medical

10a, State

Examine ed by the attending physician and detached for use as the burial-trar Physician/Medical certificate has been signed by rector, page 2 should be detact Medical Certification: To Be Completed by funeral director, within 24 hours after death

To the Funeral Director:
completely filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF F≅MALE: 23b. Was decedent pregnant in the past 12.months? 1 □ Yes 2 □ No 9 □ Unknown	23	ic. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of d	I death 3 ☐ Ectopic					23d. Date of Month	delivery Day	Year
Part II. Other significant condition	ns cont	ributing to death but not resu	ulting in the underlying	g cause	given in Part I.		23e. Did tobacco			of death?
							24a. Was an autopsy performed? 1 ∐Yes 2 🗓 N	prior	autopsy findi to completion ? es 2 □ No	of cause of
25. Was case referred to medical					26. Place of De	ath (C	Check only one)			
examiner? 1 XYes 2 ☐ No	Н	ospital: 1 Inpatient 2 I	ER/Outpatient 3 ☐	DOA	Other: 4 Nursing I	Home	5 🛱 Residence	6 ☐ Other (S	pecify)	
27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investig	ation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	1	lnjury at Work? 1 □Yes 2 □No	280	I. Describe how inju	ury occurred		
3 □ Suicide 6 □ Could r 4 □ Homicide determi		28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, offi	ice	28f.	Location (Street a City or Town, Sta	and Number or te)	Rural Route	Number,

29c. License number

20542

29d. Date signed (Month, Day, Year)

5-11-2009

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, I

110 Irving St., NW #C-2151 Washington, DC Joseph Catlett, M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 2009 Berlinski 6, 11:52 A<sup>M</sup> Gerard May Edward /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Cheverly 6127 Landover Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | April 1 198 | 1961 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 😿 M 2 🗆 F 48 047-64-2269 WA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County r than "natural", or items 23a or 28a-f show 1 Yes 2 □ No Prince George's Cheverly MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 United States 6127 Landover Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. and the filed with filem 27 is marked other than "natural", or ite nry or other traumatic event, the Medical Examines nry or other traumatic event, the Medical Examines. 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: Caucasian \$ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  $\overset{\text{Elementary/Secondary (0-12)}}{12}~\text{years}$ College (1-4or 5+) University Adjunct Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy F. Chojnowski Edward J. Berlinski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6127 Landover Road Cheverly, MD 20785 Lucretia Berlinski 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or once. Sacred Heart Cemetery May 14, 2009 Connecticut 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Si mature of Funeral Service Li 20019 4001 Benning Road Washington, DC Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or deart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Seizure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Unersee or in that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate 1 □Yes 2 No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide i 24 hours af e Funeral D letely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Brian H. Aven 2130 University Blvd. West Suite 400 Wheaton, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

2 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6.00 AM 2009 Robert Fitzgerald Cavedo Mav 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Loyalton of Hagerstown Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Dec. 9 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1∭ M 2□ F 577-50-1557 .1938 Director 70 Déc. Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the litedical Examinar must be notified at 1 □ Yes 2 N No Washington County Hagerstown Director Maryland| 10g. Citizen of What Country? 10e, Street and Number 10f Zin Code U.S.A. 21740 2009 Rosebank Wav Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Phone Company Computer Technician s 1 and 2 should be filed with thealth and Mental Hygier Item 27 is marked other the other traumatic event, Item 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willis Henry Cavedo Margaret Clegg Cavedo ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. Linda Naddeo-daughter 124 Eagles Ridge Smithsburg, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory | 5-12-2009 | Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licen: 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due tyr as a consequence of): **Physician** 5-20 mm disease or condition resulting in death) /Medical Examiner MELLITUS DEPENDENT ) ABOTET YLARLI. HSULIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed DISEASE DRONARY ARTERY and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an has autopsy performed? Yes 2 No certificate 1 □Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2√ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Medical 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGOUTOWN 16H-20 DANIR 1190 MI MI 9 (HASAU) 31. Date filed (Mor 32. Registrar's Signature State Registrar

State Registrar Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	f Marylan		artment of rtificate of			_	giene Reg. No. 2	009	16771
	Physicia		1. Decedent's Name (First, Middle, Bladen D. C	Last)						2. Date of De Month May	Day	Year 2009	3. Time of Death 2:15 A M
	/Medic Examin		4a. Facility Name (If not institution,		nber)		4b. City, Town,	or Location of	of Death	Tidy	4c. County		
	LXamm	-	Maplewood Park F	lace Heal	th Car	e	Bet	hesda			Mor	ntgom	ery
	Funeral Director		176-32-4031	6. Sex 1 <b>X</b> M 2□ F	7. Age ( <i>In yrs</i> . 96	last birthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da Dec. 1	8,1912	9. Birth Cou Man	place (State or Foreign ntry) yland
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limits
	-f shc	tor	MD Montg	omerv			Bet	hesda					1 □ Yes 2 🙀 No
	or 28a	irec	10e. Street and Number	,			10f. Zip Code			T	10g. Citizen of	What Cou	ntry?
	23a c	ral	9707 Old George	town Road	1		208	14			United	Stat	es
	tems	Funeral Director	11. Marital Status	Armed Fo	dent Ever in U.	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Ori ban, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	)- 14. Ra Bla	ce - Ameri ick, White,	ican Indian, etc.
000	rs and	by F	1 ☐ Never Married 2 ☐ Marrie  3 ☐ Widowed 4 ☐ Divorced	ed 1 XXYes If Yes, Giv Year or D	2 □ No 19: de 19:	31 <b>-</b> 65	1 □ Yes 2 🗶 N	Specify:	;		Specif	fy: W	hite
0500-c	atura	ted	15. Decedent	s Education	21.00.	16a. Dece	dent's Usual Occ	upation		-	16b. Kind of E	Business/Ir	ndustry
7 12	an "n	Completed	(Specify only highes: Elementary/Secondary (0-12)	t grade completed) College (1	-4or 5+)	(Give life.	kind of work don DO NOT use reti	e during mos red)	st of worki	ng			
7	ed will ygien <b>ier th</b>	Con		5+		Co	nsulting						ervices
מום	ntal H	Be	17. Father's Name (First, Middle, L							e Chew	, Maiden Surnai	me)	
<u> </u>	d Mer marke matic	၀	Samuel Clagget  19a. Informant's Name/Relationsh			105 14-10	Address (Ct				- City on Town	Ctoto 7	in Cado)
2 2	Ith an Ith an 27 is r		Mariamne Vicker		nter		ng Address <i>(Stre</i> Wildoak						p Code)
e .	if Hea		20a. Method of Disposition	·	20b. f	Place of Dispo	osition (Name of matory or other p	1		Date	20c. Location		own, State
	nent c		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State Ar.	lingto Cemet	n Nation	al A	ugus 200	9	Arlingt	on,	VA
Dallillor	permit. Pages I and z should be fined within 72 hours after death with the Maryland permit. Pages I and z should be fine within the permit of Health and Mental Hygiene. Important: If Ifem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examination notified at once.		21. Signature of Funeral Service L	icensee	-	2:	2. Name and Add eVol Fun	ress of Faciliteral H	lome,	10 Eas	st Deer	Park 377	Drive,
			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that c	aused the deat ach line.								Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	Pr	neumonia	a							Onset and Death
	/Medical xaminer		resulting in death)	Due to	or as a conseq	uence of):							
	.xaiiiiioi	2	Sequentially list conditions,	b	or as a conseq	Hence of):						_	
fod	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or moury that initiated events	4	, or ab a borneoq	201100 01)1							
<b>5</b>	an and rial-tra	Еха	resulting in death) Last	C. Due to	or as a conseq	uence of):							
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; è	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregi	nant at time of o own	death 5 [	Other (specify)						
ire that	signed by	ρ	Part II. Other significant condition			ulting in the u	inderlying cause (	given in Part I	1.				the cause of death?
COLUS,	been	letec	Congestive Hea	rt Diseas				-		24a. Was	- T		opsy findings available
בי קובר בי קובר בי קובר	certificate has t	Completed	Myocardial Inf							auto perfe	psy ormed? 2 🔯 No	prior to codeath?	ompletion of cause of 2 □ No
1 2	ertifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place	e of Death	(Check only			
2 9	this or		1 ☐ Yes 2 📉 No		npatient 2		III JU DOA				idence 6 □ Ot		eify)
	After	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending		of Injury th, Day, Year)	28b. Time o Injury	W			28d. Describe	how injury occu	rred	
200	death ctor: / the	icat	2 Accident Investig	ot be	of Injury - At h	ome farm str	M 1 reet, factory, office	□Yes 2□	-	28f. Location /	Street and Num	her or Ru	ral Route Number,
	after Dire	Certification: To	4 ☐ Homicide determi	ned buildi	ng, etc. (Speci	fy)	ioot, idotory, office			City or To	wn, State)	.50, 0, 114	al Floats Flambon
Hoenite	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical C		g Physician: To the Examiner: On the b and man									
Tothe	within sompl	Me	29b. Signature and title of certifier				1	nse number			29d. Date sign	ed (Month	, Day, Year)
			mal	ew	w	m	a D	35791			May 6,	2009	
	1/+/		30. Name and address of person v										0000
			Merlyn Vemury,				enue, Su	ite 22	27, S	ilver S	Spring,	MD 2	U9U2
	Sta Registra		31. Date filed (Month, Day, Year)	2009	gistrar's Signa	A. A	hares						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State	of Mary	land / [	Depa	rtment of	Health	and M	lental Hy	giene 2	009	16772
		State Registrar				Cer	tificate of	Death			Reg. No.	000	10112
Physicia	an	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath Day	Year	3. Time of Death
/Medic			Donald		Chapi	in				May	07	2009	3:05 aM
Examin	er	4a. Facility Name (If not institution,	give street and r	number)			4b. City, Town,	or Location	of Death		4c. Cou	nty of Death	1
		109 Ashton Oak 5. Social Security Number	s Court	7 Age (In	yrs. last bir	thday)	If Under 1 Year	Ashto If Under		8. Date of Birt	th		comery  pplace (State or Foreign
Funeral Director		216-40-8008	1 ▲ M 2 ☐ F	7. Age (III		Yrs.	Months Days		Min.	(Month, Da	y, Year)	Coa	intry)
		Usual Residence of Decedent				1				mpril 2	., 17-11		
rylan show	_	10a. State 10b. County		100	. City, Town	n or Loc	ation						10d. Inside City Limits
e Ma	Director	Maryland Mon	tgomery					Ashto	n				1 □Yes 2 No
after death with the Maryland or items 23a or 28a-f show	ä	10e. Street and Number					10f. Zip Code				10g. Citizen	of What Cou	untry?
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items:	5	11. Marital Status	Armed	ecedent Ever i Forces? s 2 🔀 No	in U.S.	13. W	las Decedent of Yes, specify Cu	Hispanic Or ban, Mexica	igin? (Sp n, Puerto			Race - Amei Black, White	
rs aff	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, (	Give		1	□Yes 2 No	Specify.	:		Spe	Specify: Caucasian	
filed within 72 hours Hygiene. sther than "natural", ant, Ir My Jion Exa		15. Decedent's	Education		16a.	. Decede	ent's Usual Occu	pation			16b. Kind o		
hin 7. e. an "n	ed l	(Specify only highest Elementary/Secondary (0-12)	r -	d) (1-4or 5+)	_	(Give k	kind of work done O NOT use retir	e during mos ed)	st of work	ing			
ygien ygien er th	Completed			4	Ce	rtif	ied Publi	c Accou	ntant			Self En	ployed
be file	Be (	17. Father's Name (First, Middle, La	ast)					18. Moth	er's Name	e (First, Middle,	Maiden Surr	name)	
Men Men arke	၉	Virgi	1 Chapin							Marion	Leslie		
2 sh h and is m raum		19a. Informant's Name/Relationshi	p (Type. Print)				g Address (Stree						ip Code)
t and Health		Nancy L. Chapin 20a. Method of Disposition	- Spouse	100			shton Oak ition (Name of	s Drive		ton, Mary	20c. Location		Tourn State
int of l		1 ☑ Burial 2 ☐ Cremation 3			cemetei	ry, crema	atory or other pla	ace)	ı	Jale	200. Localio	on - City of 1	OWII, State
rtant njury		4 □ Donation 5 □ Other (Spe			Fort L		In Cemeter			2/2009	Brentwe	ood, Ma	ryland
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, If "Medical Exannes.		21. Signature of Funeral Service Li	censee		ti	Hi	Name and Addi	di Fune	ral H				
		23a. Part 1. Enter the disease, or c	omplications that	t caused the	death. Do							ng, Mar	yland 20904 Approximate
Discolation		shock, or heart failure. List of Immediate Cause (Final	nly one cause or	each line.					, our undo	o	.,,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	- u.	ectal Ca			static					-	15 months
Examiner		Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):											
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eath certifi attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	outcome of pre birth 2	Fetal death		Ectopic pregnar	псу			23d.	Date of deli Month	very Day Year
the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Un	egnant at time known	e or death	5□	Other (specify)						
Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as		Part II. Other significant condition	s contributing to	death but not	t resulting in	n the und	derlying cause g	iven in Part I		23e. Did to	obacco use c	ontribute to	the cause of death?
uires sign Id be	d by									1 🗆 1	res 2 ⊠ No	o 3	obably 4 Unknown
w req	Completed									24a. Was	an 24	lh Were au	topsy findings available
he lay e has ige 2	E C									autor	rmed?	prior to death?	ompletion of cause of
sician: The law certificate has b irector, page 2 s		25. Was case referred to medical	T					26 Place	o of Doat	1 ☐ Yes h <i>(Check</i> o <i>nly</i> o		1 ∐Yes	2 □ No
yslcl <sub>k</sub> s cer direct	To Be	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	☐ Inpatient	2 □ EB/O	tpatient	3 DOA O	hor:		ome 5 🗷 Resid		Other (Spec	vifu)
iding Physin. After this of funeral directions	빌	27. Manner of Death	28a. Dat	te of Injury onth, Day, Yea	28b.	Time of njury	28c. Ini			28d. Describe			ony)
ath. r: Aff	atio	1 x Natural 5 ☐ Pending 2 ☐ Accident investiga		onin, Day, rea	1	i ijui y		∃Yes 2□	No				
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	od   286. Pla	ce of Injury Iding, etc. (S	At home, fa	rm, stre	et, factory, office			28f. Location (5 City or Tov		ımber or Ru	ral Route Number,
ital o rrs aft ral Di led in	Ö	Sily of Town, State)											
To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral	Medical	29a. Certifier 1 ☑ Certifying (Check only one) 2 ☐ Medical E	Physician: To t xaminer: On the and ma	he best of my basis of exa anner stated.	knowledge mination ar	e, death nd/or inv	occurred at the stigation, in my	time, date a opinion, de	nd place, ath occur	and due to the red at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
Vith To th	Σ	29b. Signature and title of certifier		0	7		29c. Licer	nse number			29d. Date sig		
12		1 Juns	1 -	20	50		D4	3083			May	7, 20	09
12		30. Name and address of person w					· ·						
I	- 1	Coorgo Satas M	n 9707	Modioc1	Contor	n Drei	TO Cuito	3UU D	ookwi	IIA Marri	AC barls	x5N	

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

parked

			1 - State Registrar	State of Ma	aryland		artment of H tificate of		and Me		ene () ()	9	16//3
			Decedent's Name (First, Middle, Last,	)					2	2. Date of Death			3. Time of Death
	Physici		Helen Cull	2 12						Month	9 200	ear NO	23:00 PM
	/Medic Examin		4a. Facility Name (If not institution, give	-			4b. City, Town, o	or Location of	of Death	17104	4c. County of I		
	Examili	eı		riew Medic	al Ca	مطم	1		TM DE	~-P	N	/ A	
	Funeral		5. Social Security Number 6. Se			st birthday)	If Under 1 Year	If Under		3. Date of Birth (Month, Day,			ce (State or Foreign
	Funeral Director			]M 2 <b>∑</b> F	6	O Yrs.	Months Days	Hours	Min.	(Month, Day, ) Sept. 28	Year)	Countr	yland
			Usual Residence of Decedent							зереч де	, 15.19		) Lune
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation					100	d. Inside City Limits
	Mar Mar	ţ	Maryland Cecil		P	ort D	eposit						1 ☐ Yes 2 🔀 No
	r 284	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	t Countr	y?
	3a o	0	84 Peppermint Dr				2190	4			USA		
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral	11. Marital Status	12. Was Decedent 8	Ever in U.S	. 13.	Was Decedent of It	lispanic Ori	gin? (Spec	ify Yes or No-	14. Race -		
20	be filed within 72 hours after death with the Marylan ital hygiene. id other than "natural", or iteme 23a or 28a-1 show event, the Madical Examiner must be notified at	by Fur	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 [X]N If Yes, Give Year or Dates:	lo	1	r Yes, specify Cub 1 ☐ Yes 2 🂢 No			ican, etc.)	Specify:	White, et	ite
9500-61212	hou tura	ed i	15. Decedent's Edu			16a Decer	tent's Usual Occur	nation		1	6b. Kind of Busin	ess/Indi	ıstry
Ċ	n 72	Completed	(Specify only highest grad			(Give	kind of work done	during mos	t of working	9	OB. Ring of Dusin	03311100	Johny
7	within the man	μď	Elementary/Secondary (0-12)	College (1-4or 5	+)		cher	-,			Educat	ion	
	e filed with al Hygiene. other ther		17. Father's Name (First, Middle, Last)	T		rea	CHEL	18. Mothe	er's Name /	First, Middle, Ma		1011	
/land	should be nd Mental marked o	Be	Melvin McCardell	Īr						McGloth			
_	should nd Men s marke umatic	2			1	406 14:10:	- A					4- T- C	3 de l
Mar	01 42 25 42		19a. Informant's Name/Relationship (T)		i		ng Address (Street				-		
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altimore,	if ite		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ F	Removal from State	cei	metery, crer	natory or other pla	сө)	5-13-	2009	uc. Location - Cit	yorlow	m, State
E	2 2 2 2		4 ☐ Donation 5 ☐ Other (Specify)		R.T	. Foar	d Funera				ising Su	ın, l	Maryland
g	permit. F Departme Importar eny Injur		21. Signature of Funeral Service License	ee Os di	•		Name and Address R.T. Foa:	rd Fu	neral	Home, H	P.A.	219	11
			23a. Part J. Enter the disease, or compl	lications that caused	the death.	Do not ent	er the mode of dyi	ng, such as	cardiac or	respiratory arres	st,		Approximate
			shook, or heart failure. List only o	ne cause on each lin	10.								nterval Between Onset and Death
1	Pnysician /Medical		disease or condition resulting in death)	. Kesp		CY +	ailure						
M	Examiner			Due to (or as			11		2				
		_	Sequentially list conditions,	b. Intra	venti	ricul.	or Herr	MOLL	though	3		_	
	sit s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Doe to (or as	a conseque	siles oi).			)				
	and -tran	кап	that initiated events resulting in death) Last	c Due to (or as	2 00000000	anna of):							
Ď,	certificate be executed Iding physicien and Ise as the burial-transit	E		Due to (or as	a conseque	51100 01).							
9/8 1	cate ohysi the t	dlcal		d						<del></del>			
٥ ×	eath certific ettending p for use as	Me	IF FEMALE:	70 H					250		200		
X Q	death c e ettenc ed for us	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal o	death 3	Ectopic pregnanc	у			23d. Date of Month		y Dav Year
-	e de l'he e	slc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of dea	ath 5	Other (specify) _						-,
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ń	requires that een signed b nould be deta	þ	Part II. Other significant conditions co	ntnbuting to death bi	ut not resul	ting in the u	nderlying cause gi	ven in Part I			acco use contribu		
ecora	equir en s	Completed								1 🗆 Yes	s 2 No 3	] Proba	bly 4 □Unknown
ပ္သ	2 5 8	ple								24a. Was an autopsy	24b. We	re autop	sy findings available pletion of cause of
r	0 - 0	Eo								perform	ed2 dea	th? Yes 2	
VII	icien: Th certificate ector, pag	0	25. Was case referred to medical					26 Place	e of Death	(Check only one	\$	103 2	
	S 5	0.0	examiner?	Hospital: Inpatie	nt 2∏F	R/Outpatier	t 3 DOA Ott	hoc			nce 6 Other	Specify	
Ö	Phys ar this aral di		27. Manner of Death	28a. Date of Injur (Month, Da)		28b. Time o					w injury occurred	Opochy)	
5	th.	亨	1√Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	/ Year)	Injury		rk? ]Yes 2.∐	No				
UNISION	Attending r death. ector: After by the fune	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At hon	ne, farm, str	eet, factory, office		28	Bf. Location (Stre	eet and Number	or Rural	Route Number,
<u> </u>	after Dire	Certification;	4  Homicide determined	building, etc	: (Specify)					City or Town,	State)		
	Hospitel 14 hours 2 Funeral 1		29a. Certifier 1 Certifying Phy	sician: To the best	of my know	ledge deat	a occurred at the ti	me date ar	nd place ar	nd due to the car	use(s) and mann	er as sta	ted
	24 h	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination	on and/or in	vestigation, in my	opinion, dea	th occurred	d at the time, da	te and place, and	due to	the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b Signature and title of certifier				29c. Licens	se number		29	d. Date signed (/	Month, D	Pay, Year)
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			4	- Jona	( han	cell	en ms	14	-7 ~ C		may	7	2009
	5		30. Name and address of person who co	ompleted cause of d	eath (Item :	23a) (Type,	Print)		70	ı	,		
			Jonathan Zelt 31. Date filed (Month, Day, Year)	en 4	1940 r's Sinnati	Ta st	en Hve	mue	17als	nona,	MD. 2	122	-4
	Sta Registr		MAY 1 2 2009	A	A. A	backs	29c. Licen: Print) PRN AV6						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician COOP 200 Virginia IlVn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstowi If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Min Days Hours 1 ☐ M 2 ☐ F March 19,1919 219-10-7910 Maryland Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Wittman Director MDTalbet 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 2. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify: Specify. Completed by 3 ₩idowed 4 Divorced Black 'natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) County Board of Education of Health and Mental Hygiene. item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) brarian 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ANANIAS Chambers EMMa Mc Gowan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12d. Randallstowin, MD. Carliss 20c. Location - City or Town, State Date 20a. Method of Disposition Department of F Important: If ite any Injury or oth once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hurlock, Veterins Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addres of Facility 21. Signature of Funeral Service Licensee Henry Forveral Home, P.A. SIO Washington Streambridge, MD. 2/6/3 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PREBLOURSCULAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of: Physician/Medical Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Haknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 To the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 9:10 PM Ida Catherine Cannon 6,2009 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctors Community Hospital Lanham 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 X F 94 May 16, 1914 230-09-3244 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, Inc. Inc. Item In 1 X Yes 2 □ No Director Cheverly Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 USA 2310 Cheverly Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence C. McQuain Pleasant Propst and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any injury or other traun once. 2310 Cheverly Avenue, Cheverly, MD 20785 Edward C. Cannon / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/13/2009 National Memorial Park Cem. Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Lews 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed and burial-tran P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Dav 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ပ D 34722 67 of person who completed cause of death (Item 23a) (Type, Print) By 5432 ANNAPOLIS RUAD PLADENSBURG MO State Registrar

# VOID

certificate no.: 2009 16776

11 5/09h

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:25 P M 2009 11Elizabeth Detwiler May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rising Sun
If Under 1 Year | If Under 24 Hrs. Cecil Calvert Manor Healthcare Center Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F Pennsylvania 164-07-2635 97 July 2, 1911 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. where of the than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Delaware New Castle Newark 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19711 USA 912 Rahway Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No White Completed by 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Clothing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Anna Henderson Edgar Gibbs 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an 912 Rahway Dr., Newark, De 19711 Catherine Taylor/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 5-15-2009 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Broomall, Pennsylvania injury 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Memorial Gardens 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service License any 111 S. Queen St., Rising Sun, MD 21911 uchara Approximate Interval Between Onset and Death 23a. Pa. 1. Enter the disease, or complications to at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shyck, or heart failure. List only one cause on each line. Immediate Cause (Final day Myocardial Physician disease or condition resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Year signed by the atte Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl one Be examiner? Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours after e Funeral Direc To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated within 2. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 09 D0028324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEIL E. 101 COLONIAL Way LATTIN 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 12 2009 Registrar

	3754 ert Edward D		Please Type o	r <b>Print in Bla</b> of Maryland /	<b>ck Indelil</b> Departme <i>Certifica</i>	ent of H	eaith a	re All Co nd Menta	pies Ar I Hygien	e Legik Ie Reg. I		20	09	1677
		R	egistrar . Decedent's Name (First, Middle,Las	1)		10 0, 2			2. Date Mon	of Death		ar	3. Time of I	
Med	Physicia lical Exami		Robert Edward I						May	10, 200	9		1126 h	IFS
			a. Facility Name (if not institution, giv 2901 Coastal Highway			1	City, Town, Ocean Ci	or Location of D ty			4c. County Worces	ster		
	Funeral Director		Social Security Number 6. S 220–92–8919	7. Age	(In yrs. last birth	,,	f Under 1 Y Months D	ear If Under 2 Days Hours		ate of Birth (19/29/1		Forei	rthplace (Sta gn ountry) Ma	aryland
		-	Jsual Residence of Decedent			1							10d. Inside	e City Limits
	v any		0a. State 10b. County		10c. City, Town	lisbur	·v						1 X Yes	s 2 No
P	death with the Maryland or items 23a or 28a-f show must be notified at once.	ē	Maryland Wicomi		- Da.		Of. Zip Cod	e		10g	Citizen of V	Vhat Co	untry?	
9	Mary r 28a- ed at	Director	10e. Street and Number				·	21801			USA			Ì
472	th the 23a o notifi		1505 Jersey Roa	12. Was Decedent	Ever in U.S.	13. Was D	ocedent of	Hispanic Origin	n? ( Specify \	es or No-	14. Ra		erican Indian,	Black,
	ath wi	Funeral	1 Never Married 2 Marrie	Armed Forces?	X No	If Yes,	specify Cu	iban, Mexican, i	Puerto Rican	, etc.)	1	1.7	hite	
	ter de	린		d If Yes, Give Year or Dates:				No specify:			Specify 6b. Kind of	/.	_	
	urs af Itural	q p	15. Decedent's Education (Specify	only highest grade com		Decedent's	Usual Occ	upation (Give ki Jife. DO NOT u	ind of work do use retired)	one 1	6b. Kind of	Busines	s/industry	
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	003( within iene. er tha	ompleted	12 17. Father's Name (First, Middle, Las	4\		Painte	er	18.Mother's	s Name (First	, Middle, Ma	aiden Surna	me)	<u>10,cu</u>	
	filed I Hyg	Be Co	Ray Neil Dearb					He1	en Eli	zabet	h Gate	es_		
	212 ald be Menta marko	To B	19a. Informant's Name/Relationship					Street and Num						
	AD 2 short h and 27 is neartified		Ray Neil Dearbo	rn - Fathe	r	2441 (	Cummi:	ng Wood	s Ln,	Hende	20c Locatio	ille on - City	or Town, Sta	.8739ate
	e, N I and Healt item		20a. Method of Disposition  1 Burial 2 Cremation	Removal from St	crema	tory or othe	r place)	of cemetery,						
	Pages ent of net: If		4 Donation 5 Other Speci	fy:	Balti	more	Crema	tory _	5/15/	2009	Balt:	imor	e, MD	Tn:
	Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health is and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service Lic	ensee		22. Na	me and Ad	of Glo	John	M. Ta	ylor !	rune	rai no	ome, Inc
	<b>w</b> §9 ē		Myelin T.  23a. Part I. Enter the disease, or co	Western that sause	the death Do	14 /	mode of d	ying, such as c	ardiac or resp	oiratory arre	st, shock, or	heart	Approx	kimate Interval
	Physiciar Medica		failure. List only one cause on	each line.									Detwe	Death
Ą	.amine		Immediate Cause (Final disease or condition resulting in death)	a. Narcotic  Due to (or as a cons		ation								
		iner	Sequentially list conditions, if any, leading to immediate cause.	Due to (or as a cons	sequence of):									
	ed	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons					- 4 00					
	e execut cian and rial - tra	sician/Medical	X UNPENDED	AMENDED 23	3a,27,28		erME,	g892 (	5/12/0 ———	9 TT	23d. Da	te of del	iverv	
	760 icate t	₹	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	ome of pregnant		al death	3 Ectop	ic pregnancy		Mor		Day	Year
	c 68	ciar	past 12 months?	4 Pregnant	at time of death		ner (Specif	y)			1			
	Boy death	Physi	1 Yes 2 No 9 Unkn		Alle Barrer	tine in the H	ndorlying c	ause given in F	Part I.	23e. Did to	bacco use	contribu	te to the caus	se of death?
	of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed.  After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and the physician and the physician and the physician and the physician are set to be purished for use set the burial - transit	J A		ns contributing to dea	ath but not resul	ung in trie o				1 Ye				Unknown
	ds, equire een si	Completed								24a. Was auto	osy	prio	r to completion	ndings available on of cause of
	COF law r has b	a								perfo	ormed?		ith? Yes	2 No
	Re The	3		Т			26	3.Place of Deat	h (Check only	one)				
	ital sician is cert	8	examiner?	Hospital: 1 Inpa	itient 2 EF	₹/Outpatient			Nursing H				Other: Scene	
	of V g Phy fter thi	uneral unector, page	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of I		Bb. Time of I	njury 28	Bc. Injury at Wo		d. Describe Ink	how injury o	occurred		
	on o		1 Natural 5 Pendi	19 Ed 5/1	0/09 F	d 11:	05 am	1 Yes 2			(Carpot and	Number	or Rural Rou	ite Number, City
	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and the funeral Director: After this certificate has been signed by the attending physician and the funeral Director: After this certificate has been signed by the attending physician and the funeral Director: After this certificate has been signed by the attending physician and the funeral Director.	ortification.	2 Accident Invest 3 Suicide 6 X Could 4 Homicide	not be nined (Specify)	f Injury - At home Found:	in tr	avel	traller		or Town, )cean	State) 29 City,	MD	oastal	Hwy
	e Hospit 1 24 hour e Fuuera	=   C	20a Certifier	ysician: To the best of	f my knowledge, examination and	death occu	rred at the	time, date and opinion, death	place, and du	ie to the cau ne time, dat	use(s) and m e and place,	anner a	s stated. e to the cause	e(s)
	To th within To th	Modical	29b. Signature and title of certifier	and manner state	ed			. License numb			29d. Dat	e signed	(Month, Da	y, Year)
	_	1 10	1 -20. 2.9, 2.0.0				- 1				1 44- 4	4 200	0	

State 31. Date filed (Manth, Day Xear) Registrar

O.C.M.E.

May 11, 2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Ce	rtificate of	Death		Reg. No.	2009	16/19
-	Physici	22	1. Decedent's Name (First, Middle, L	.ast)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi		ELIZABETH	DANIEL					6 20	009   009	10:40 AM
	Examir	ner	4a. Facility Name (If not institution, g				or Location of Dea			ounty of Death	on!a
			FORT WASHINGTO  5. Social Security Number 6.		on to at hinth day.	FORT V	VASHINGTO  r   If Under 24 Hrs			NCE GEO	
	Funeral Director		231-01-9670 Usual Residence of Decedent	Sex 7. Age (In ye	rs. last birthday) Yrs.	Months Days			y, Year) 1913	VIRG	ace (State or Foreign try) INIA
	/land ow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10	Od. Inside City Limits
	a-f sh	ctor	DC		WASHING	TON					X Yes 2 No
	or 28	)ire	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Coun	try?
	ath w	ral	2611 BOWEN ROAD	S.E. # 40		2002			USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X No	Hispanic Origin? ( ban, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		. Race - America Black, White, e pecify: BLA	etc.
2-0	72 hc "natu die-i	etec	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece (Give	dent's Usual Occ	upation e during most of wo ed)	orking	16b. Kind	of Business/Ind	ustry
121	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 1 YR		DO NOT use retir E WIFE	ed) -		PRIV	٨πΕ	
d 2	filled Hygin other ant, th	ပို	17. Father's Name (First, Middle, La.		HOUSE	MILE	18. Mother's Na	me (First, Middle,			
lan	fental fental rked c	To Be	JOHN ALLEN				MARY			•	
Maryland	alth and N		19a. Informant's Name/Relationship JOYCE Y. DANIELS/				et and Number or F DAD S.E.				
Baltimore,	Pages 1 annent of He		20a. Method of Disposition  t☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Speed	☐Removal from State	cemetery, cre-	osition (Name of matory or other pl ECTION CI	ace) EMETERY 5	Date /14/2009		tion - City or To	
Balti	permit. Departr Importa any Inju		21. Signal Fundral Service Lic	ensee		2. Name and Add	ress of Facility J	. B. JEN D LANDOV			
68760,	hysician and as the burial-transit as the burial-transit	Medical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const	_	LO W			Approximate Interval Between Inset and Death		
P.O. Box 6	ath ce ttendir or use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pregnan	су		230	d. Date of delive Month	ry Day Year
	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause g	iven in Part I.				e cause of death?
al Records,		Completed						24a. Was autor perfo 1∐ Yes	rmed?	prior to con death?	osy findings available npletion of cause of 2☑ No
Vital	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:				eath (Check only o	ne)		
Division or	Ing Phys After this Ineral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inj		Home 5 Resid			)
Divis		Certification:	3 Suicide 6 Could not determine		t home, farm, str ecify)	reet, factory, office	•	28f. Location (S City or Tox	Street and N vn, State)	Number or Rura	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifying F (Check only one)	Physician: To the best of my k aminer: On the basis of exami and manner stated.	knowledge, deat ination and/or in	h occurred at the	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) ar date and pl	nd manner as st lace, and due to	ated. the cause(s)
	5	Ž	29b. Signature and title of certifier	Halalao	m ph		604k	5		signed (Month, I	
	B		30. Name and address of person wh A.M. ALIKHANI M.			,	WASHING	TON, MARY	LAND	20747	
	Sta Registr	te ar	31 Pate filed (Month, Pay Year) 1 2009	32. Registrar's Sig							

09-03786	
Charil C. Douglas	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aril C. Dougla		State of Maryland	d / Department of <i>Certificate of</i>	Health and Mental Hy		200	9 16/8
Physicia	F	legistrar 1. Decedent's Name (First, Middle,Last)	Certificate of		Reg. N 2. Date of Death	3	. Time of Death
edical Exami	3116	Charil Cord			Month Da May 11, 2009		1558 hrs
		4a. Facility Name (if not institution, give street and numb	er) 4	b. City, Town, or Location of Death  Cheverly		4c. County of Death Prince George's	
		Prince Georges Hospital Center  5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth(M	M/DD/YYYY) 9. Birthp	
Funeral Director		249–98–5365 1 X M 2 F	54 Yrs.	Months Days Hours Min.	May 23,	Foreign Coun	try) SC
	-	Usual Residence of Decedent			114) 209		
any	Ī	10a. State 10b. County	10c. City, Town or Locati				0d. Inside City Limits  1 X Yes 2 No
Aaryland 28a-f show any 1 at once.	ē	DC		Washington	n 10g.	Citizen of What Countr	
Mary r 28a-	Director	10e. Street and Number # 5 Bass Circle # 201		20019	1 - 3	United S	
ith the s 23a c 23a c		11. Marital Status 12. Was Deced	ent Ever in U.S. 13. Wa	s Decedent of Hispanic Origin? ( Sc	ecify Yes or No-	14. Race - America	
eath w	Funeral	1 Never Married 2 Married Armed Force	2 X No	es, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after d al", or	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		Yes 2 X No specify:  nt's Usual Occupation (Give kind of v	work done	Specify: Blac  Bb. Kind of Business/Inc	
hours natur Exam		15. Decedent's Education (Specify only highest grade  Elementary/Secondary (0-12) College (1-4)	during m	ost of working life. DO NOT use reti		D. King of Eddinose	,
36 hin 72 e. than tadical	Completed	12th	0.01)	Cook		Priv	ate
21215-0036 unid be filed within 7 Mental Hygiene. marked other than	S	17. Father's Name (First, Middle, Last)		18.Mother's Name	(First, Middle, Mai		
121 I be fil ental H arked vent,	Be	Thomas Douglas  19a. Informant's Name/Relationship (Type, Print )	19h Mailin	g Address (Street and Number or I		en Hinton	Zip Code)
MD 2 td 2 should tith and M m 27 is m aumatic e	٥	William Douglas/ Brother		8th Street N.E.	Washingt	on, DC 20	0019
and 2 Health item 2		20a. Method of Disposition	20b. Place of Dispos	sition (Name of cemetery, ther place Cemetery	Date 2	20c. Location - City or T	own, State
nor Pages I ent of I nt: If		1 X Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	Pineville	AME Church May	20, 200	9 Rock Hi	11, SC
Baltimore, MD 21215-0036 permit. Pages I and 3 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera in Propertment of Health and Mental Hygiera in Innorvant. If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Signature of Funeral Service Licensee	11 11 22	Name and Address of Facility Ste	wart Fun	eral Home,	Inc. DC 20019
		23 . P of I. Enter the disease, or complications that cau	sed the death. Do not enter	001 Benning Road	or respiratory arrest	, shock, or heart	Approximate Interval
Physician Medical	16 N	failur List only one cause on each line.	e intoxicatio				Between Onset and Death
caminer		Imme a e Cause (Final disease or condition resulting in death)  a. COCALII  Due to (or as a condition or condition)					
	<u> </u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a condition)	onsequence of):				
	Examiner	cause. Enter Underlying Cause					
cuted ind transit	Exa	events resulting in death) Last	onsequence of):				
9 2 1	edical	X UNPENDED AMENDED 2	3a,27,28a-f, <sub>F</sub>	oerm,E g891 5/2//	709 TT		
760, cate be ex physician	/Mec	and that it is a second of the	utcome of pregnancy	Tetal death 3 Ectopic pregr	nancy	23d. Date of delivery Month	Day Year
Sox 6876( leath certificate e attending physion se as the b	sician/M	nest 12 months?		etal death 3Ectopic pregr Other (Specify)	lancy		
Box e death the atte	Physi	1 Yes 2 No 9 Unknown 9 Unknow		ni wa in Dani I	23o Did toh	acco use contribute to	the cause of death?
<b>sion of Vital Records, P.O. Box 6876(</b> Attending Physician: The law requires that the death certificate death.  retor: After this certificate has been signed by the attending physician: the fineral director, page 2 should be detached for use as the by the funeral director, page 2 should be detached for use as the by	by P	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.		2 No 3 Prob	
ords, F w requires is been sign should be					24a. Was ar		topsy findings available completion of cause of
COTC law re has be	1 5				autopsy perform	ned? death?	
/ital Rec ysician: The l his certificate l director, page	3	25. Was case referred to medical		26.Place of Death (Chec			
of Vital Records,  ng Physician: The law requir ther this certificate has been s neral director, page 2 should 1	o Be		patient 2 🗸 ER/Outpatie			Residence 6 Othe	r:
ing Ph After t	۱ ټ	27. Manner of Death 28a. Date (Month,	Day,Year)	A Vec 2 Vhic	unk	ow injury occurred	
SiOn Vitend death. rctor:	gţi	2 Accident investigation 280 Place	11/09 Fd 2:	reet, factory, office building, etc.		treet and Number of Ri	ural Route Number, City
Division pital or Attendir ours after death. teral Director: A	Certification:	3 Suicide 6 X Could not be determined (Specify)	house	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	or Town, Sta Washingt	on, DC	PI., N.E.
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			of my knowledge, death occ f examination and/or investig	curred at the time, date and place, and pation, in my opinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as sta and place, and due to the	ted. ne cause(s)
To t withi To tl	Medical	29b. Signature and title of certifier	ated.	29c. License number		29d. Date signed (Mo	
	-	James Presholl Mi		O.C.M.E.		May 12, 2009	
0		30. Name an and of person who completed cause		444 Dann Chaot Daltiman	MD 21201		
1/			gistrar's Signature	111 Penn Street, Baltimore	, IVID 2 1201		
Regi	State	MAY & 0 0000	A. Berle				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State of Maryland / Dep   - State Registrar	rtificate of Death	Reg. 1	711114	16781
	Dhysisia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month May 8, 200	Day Year	3. Time of Death
	Physicia /Medic		Howard B. Dunc	4b. City, Town, or Location of Death		9 Ic. County of Death	11:15 AM M
	Examin	er	4a. Facility Name (If not institution, give street and number) Brighton Gardens Tuckerman Lane	Bethesda		Montgomery	
	Funeral Director		5. Social Security Number 6. Sex 1 欧州 2 日 7. Age (In yrs. last birthday, 97 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yes 12/26/1911	ar) 9. Birth Cou	place (State or Foreign Illinois
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl a-f sho	ţo	Maryland Montgomery Bethesda				1 □ Yes 2 🙀 No
	ith the	Director	10e. Street and Number	10f. Zip Code		Citizen of What Cou	ntry?
	eath w	Funeral	5502 Spruce Tree Avenue  11. Marital Status  12. Was Decedent Ever in U.S.  13.	20814 Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto		SA 14. Race - Amer	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Memtal Hygiene.  ttem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Modical Examiner must be notified at	by	Armed Forces?  1 □ Never Married 2 □ Married  3 ▼Widowed 4 □ Divorced  Armed Forces?  1 ▼XYEs 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 1 No Specify:	Rican, etc.)	Black, White	hite
15-0	"natur	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)		Kind of Business/li	ndustry
Maryland 2121	s withir giene. r than	фшо	Flementary/Secondary (0-12) College (1-40r.5+)	acturer Agent		Self-Employe	ed
פ	be filectal Hyger of tall Hyger of tall Hyger of the event,	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maio	len Surname)	
<u>₹</u>	d Men marke matic	ဥ	Frank D. Duncan  19a. Informant's Name/Relationship (Type. Print)  19b. Mai	ing Address (Street and Number or Run	Howard ral Route Number, Cit	ty or Town, State, Z	ip Code)
<u>≅</u>	nd 2 sl alth an 27 is r rrtraur		1 1,11	Spruce Tree Avenue Bet			
Baltimore,	ages 1 and 2 ant of Health it: If item 27 y or other tr		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, credit contact the state of	ematory or other place)		Location - City or I	
Baltir	permit. Pages 1 am Department of Heal Important: If item 2 any injury or other once.		- Bernatan - Bernatan (epitology		eorge P. Kala	as Funeral I	
			23a. Fart / Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each time.			-	Approximate Interval Between
an Park	Physician		Immediate Cause (Final disease or condition	ilure.			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or a a consequence of):	m prema	ma.		l,
	73 +	ner	Se grentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	in previous	Lastin		
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c.  Due to (or as a consequence of):	me theen /		4	
68760,	rificate be executed ig physician and as the burial-transit		200 10 (0. 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.	Wim,	/		
		ledical					
P.O. Box	e death certific the attending p	Physician/N		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	ivery Day Year
ds, P.	uires that the de n signed by the Id be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	f	o the cause of death?
Vital Records,	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Completed			24a. Was an autopsy performed 1 Yes 2X	prior to death?	utopsy findings available completion of cause of
Vita	ysician: The is certificate hidirector, page	æ	25. Was case referred to medical examiner? Hospital:	Othor: 5	th (Check only one)	0 5000-10	
	Attending Physician: r death. ector: After this certific. by the funeral director, p	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 Residenc 28d. Describe how		city)
ion	tending Ph leath. tor: After th the funeral	atio	K⊠ Natural 5  Pending (Month, Day, Year) Injury 2  Accident investigation	M 1 □Yes 2 □No			
Division of	or Attencater death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S		ıral Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifler (Check only one)  1XXCertifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cau- urred at the time, date	se(s) and manner a and place, and due	s stated. e to the cause(s)
	To the within To the compl	Me		29c. License number	29d	Date signed (Mont	h, Day, Year)
	15+1		· AN OU	1053691		110/	11. 00
	21		30. Name and address of person who completed cause of death (Item 23a) (Typ  ATAY RAW MY  3200 T	Durer Ours 15	Ivd, su	he #110	Rouvill
	Sta Regist		31. Date filed (Month, Day, Year)  NAY 1 2 2009  32. Registrar's Signature	,			pro 10812

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 ၁၀၇၅ **Physician** THERESA 4:35₩ DUKULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW CARE CENTER Date of Birth (Month, Day, Year) 1/20/1941 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 □ F LIBERIA 68 217-59-7543 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at BALTIMORE 1 Yes 2 □ No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number LIBERIA 21216 3514 FOREST PARK AVE., Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No 14. Race - American Indian, Black, White, etc. 1. Never Married 2 Married 1 ☐Yes 2 XNo BLACK Specify: Yes Give à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce. MAIMA MASSALLY EDWARD G. WATSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3514 FOREST PARK AVE., BALTIMORE, MD. 21216 STANLEY BURGESS/HUSBAND 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/6/2009 CHURCH CEMETERY TUBMANSBURG, LIBERIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAPITOL MORTUARY permit. 21. Signa pre7 f Funeral Service Li nsee 1425 MARYLAND AVE., NE WASH., DC 20002 23a. Part 1. Enter the disease, or c shock, or heart failure. List of mplications that caused the death. Do tot enter the mode of dying, such as cardiac or respiratory arrest, y one cause on much line. Approximate Interval Between Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed and burial-tran Due to (or as a consequence of) has been signed by the attending physician le 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death. To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 | Yes 2 | ■ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State Registrar

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

use of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signature

			For State	State of Ma	aryland		rtment of H		nd Men		giene Reg. No.	2009	16783
Г	T.B.		Registrar  1. Decedent's Name (First, Middle, I	ast)		007	imeate or i	Douth		Date of Dea		Year	3. Time of Death
6	Physicia /Medic	al	Orita El	lis			4b. City, Town, o	r Location of	M	lay	8	2009 county of Death	2032 M
	Examin	er	4a. Facility Name (If not institution, g	1 1 00	ilCo	untu	Elkto		Deau			ecil	
3 .	Funeral				e (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2		Date of Birt Month, Da	h v. Year)	9. Birth	place (State or Foreign ntry) aryland
ŀ.	Director		Usual Residence of Decedent		02					lay	2,19		
	larylan show ed at	j.	10a. State 10b. County  Delaware New C	Castle		Town or Loo Newark							10d. Inside City Limits 1X Yes 2 □ No
	r 28a-f	Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Cou	ntry?
	th with		5A Independence	Circle			1971					JSA	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 🛣 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 X			Vas Decedent of H f Yes, specify Cuba □ Yes 2ሺ No	lispanic Orig an, Mexican, Specify:	jin? (Specify , Puerto Rica	Yes or No an, etc.)		4. Race - Ameri Black, White Specify: W	
Maryland 21215-0036	72 hou natura dical E		15. Decedent's (Specify only highest	Education grade completed)		(Give	lent's Usual Occup kind of work done	durina most	of working		16b. Kind	d of Business/Ir	ndustry
12	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		00 NOT use retired aurant 0	,			Ov	wn Busi	ness
م 2	e filed al Hygi i other vent, t	Be C	17. Father's Name (First, Middle, La	ist)					r's Name (Fi		Maiden S	Surname)	
Зa	ould b d Ment narked natic e	户	James McQuistia  19a. Informant's Name/Relationship			10h Moilig	g Address (Street		ice Wi		er City or	Town State 7	in Code)
	and 2 shealth and n 27 is r		Sandra Morris/I				lowe11's					19701	<i>p</i> <b>600</b> 00)
ore,	es 1 a of Hes fitem or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		Cal	ace of Dispo metery, crer	sition (Name of natory or other pla	ce)	Date		20c. Loc	ation - City or T	own, State
altimore,	t. Pages rtment of l rtant: If ite		4 □ Donation 5 □ Other (Spe	ecify)			emetery		-12-20	1		on, Mar	yland
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		21. Signatur Funer Service Li	C- MI	Lefte	$$ $\stackrel{\hat{R}}{1}$	Name and Addre T. Foar 22 West	d and Main S	Jones St., N	, Inc	DE	19711	
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	_a Ische	emic	Do not ent		ng, such as	cardiac or re				Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in dealth)	Due to (or as	a conseque	ence of):							
	T E E	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ence of):							
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):							
8760,	cate be executed physician and the burial-transit	dical E		d									
ဖ	ertifica ling ph e as th	Medi	IF FEMALE:	00- 14									-16
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3□	Ectopic pregnanc Other <i>(specify)</i>	у			2	3d. Date of deli Month	very Day Year
Division or Vital Records, P.O.	es that igned b		Part II. Other significant condition	s contributing to death b	out not resul	ting in the u	nderlying cause give	ven in P <i>ar</i> t I.			tobacco us Yes 2		the cause of death?
örd	w require been sign	Completed by	Huner-tension	20100 100	criqu		1100			24a. Was			topsy findings available
Rec	The law e has l	lduc	Achalasia	77 1						auto		prior to death?	ompletion of cause of
Ita	Physiclan: The lave this certificate has all director, page 2	BeC	25. Was case referred to medical examiner?					26. Place	of Death C			1 1 1 1 1 1 1 1	2010
or V	Physic this ce al dire	은	1  Yes 2 No 27. Manper of Death	Hospital: 1 Inpatie		R/Outpatier 28b. Time o	K 3 D DOA			5 ☐ Res		Other (Spec	cify)
HO	nding th. :: A ter e fur er	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da		Injury	Wo	rk? ]Yes 2∐1		. Describe	non mjarj	, 00001104	
Vis	or Attend fter death Director: , in by the f	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flace Ul III	jury - At hor tc. (Specify)	ne, farm, str	eet, factory, office		28f.	Location ( City or To	(Street and wn, State)	Number or Ru	ıral Route Number,
0	Hospital o		29a. Certifier 1 Certifying	Physician: To the best	of my know	vledge, deat	h occurred at the t	ime, date an	nd place, and	f due to the	e cause(s)	and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours, fler death.  To the Funeral Director: A ter this certifics completely filled in by the funeral director, t	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner st	of examinati	ion and/or in	vestigation, in my	opinion, dea	ath occurred	at the time	, date and	place, and due	to the cause(s)
	To the within 2 To the complete	Ä	29b. Signature and title of certifier	er Loi	ie		29c. Licens	se number 834	7		29d. Date	e signed ( <i>Mont</i> XY &	h, Day, Year) , 2009
	4		30. Name and address of person we Elizabeth Lor	MP. MD I	II W.	Hiou	STREET	Suit	te 20	3,1	EIE	ton, M	D 21921
	Sta Regist		31. Date filed (Month, Day, Year) MAY 122	009 Sentua	rar's Signat	fran	Ke						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 05/16/2009 **Physician** 8:00A Clare N. Easter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Greensboro 404 Cedar Lane If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF 262-34-1612 10/23/1911 97 Director Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location show 1 ☐ Yes 2 TxNo ral", or items 23a or 28a-f st Examiner must be notified Director Greensboro Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21639 404 Cedar Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🐴 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify: White þ 3 X Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within h and Mental Hygiene. 7 is marked other than ' than Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Gunnell Neebe Henry Jacob Neebe ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 ls 21639 404 Cedar Lane, Greensboro, MD James H. Easter/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Pages 1 permit. Pages 1
Department of H
Important: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 5-22-2009 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Fleegle and Helfenbein Funeral Home 106 W. Sunset Ave., Greensboro, MD 21. Signature of uneral Service Licensee 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CULE **Physician** Due to (or as a conservence of): disease or condition resulting in death) /Medical Examiner EXTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine executed burial-trar Due to (or as a consequence of): Box 68760. ed by the attending physician detached for use as the buria e Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 ♣ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 2 Unknown icate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performe or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. ours after death.
neral Director: A 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check onl and manner stated. Day, Year) 29d. Date signed (Month) 29h Signati DENTON MD 216

State
Registrar
ODHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signatu

2 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:05 P M 2009 MAY 09 WILLIAM R. EVANS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brooke Grove Rehab. & Nursing Center Montgomery Sandy Spring If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth
1 1 Day, Year, 1 2 2 2 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Wash., Hours D.C. 11 M 2□F 88 579-18-1979 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ∜⊞Yes 2 No Director 01ney Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20832 3904 Barnsley Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 哲 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2 No White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Federal Government College (1-4or 5+) Factory Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annette Koester Jasper D. Evans ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3904 Barnsley Lane 01ney, MD 20832 19a. Informant's Name/Relationship (Type. Print) Hazel B. Evans/wife Department of Healt Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 05-14-09 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Many Hedgman Suitland, MD 20746 Cedar Hill FH 4111 PA Ave. Approximate Interval Between Onset and Death 10 yrs. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Concestive Heart Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 **ASPVD** 2 7 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an autopsy performed Chronic Atrial Fibrillation 1 ☐Yes 2 ☐No 2 No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

Examiner executed attending physician and for use as the burial-transit Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physiciar completely filled in by the funeral director, page 2 should be detached for use as the buris. P.0. Division of Vital Records,

28a-f show

s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Items 23a or 28a-f show litem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the faciliar it is marked in the marked and other traumatic event, the faciliar it is marked.

Pages 1 ment of H

Baltimore, Maryland 21215-0036

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27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1 V Natural 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

D 001212

29b. Signature and title of certifier

and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

05-11-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Sengstack MD 3929 Ferrara Drive Aspen Hill, Maryland 20906

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Gillis 05 15 09 Jacqueline Jo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND WMHS-BRADDOCK CAMPUS Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Mar 30, 1932 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F<sub>V</sub> 234-52-5228 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Madical Examiner must be notified at MD Allegany Mt. Savage 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code P.O. Box 364 21545 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □Yes 2 □ No 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ Mo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. Specify. þ white 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) restaurant cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Mary Holt Joie Helmick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mt. Savage P.O. Box 364 MD 21545 Edwin Gillis husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/19/2009 Sunset Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. P. rr1. Enter the direation, or 'bmp/cation/ that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, it heart failur. List inly ne cruse on each line. Approximate Interval Between Onset and Death OCARDIAL LIVEARCTIVIN Immediate Cause (Fin II day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIOVASCULAR ALTERIOSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗹 No 1 ☐ Yes 3 Probably 4 ☐ Unknown 510518 Completed 24b. Were autopsy findings available prior to completion of cause of death? tenal 24a. Was an autopsy performed/ risht hemi pleale 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2∭No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15 AV 1600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hazen Ra. HE camperiana Mp. 21502 F. Manget 445 ponala 31. Date filed (Month, Day, Year) NAY 26 200 istrar's Signature State Registrar

09-03626 Ina Gravton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1- For State 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Da May 5, 2009 2256 hrs Tna C. Grayton Medical Examine 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. Foreign Washington Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days Director 1942 Yrs 578-64-4623 М 2X F 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 1 Xyes 2 No aitimore, MD 21215-0036

mit. Pages I and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene.

orfant: If item 27 is marked other than "nater". Glenarden 28a-f show Maryland Prince George's Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 20706 7911 Grant Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married 2 X No Yes Specify: Black Yes 2 X No specify: If Yes, Give Year 4 X Divorced Widowed 16b. Kind of Business/Industry ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Government Legal Secretary 2+18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Idella White William A. Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 3528 Rippling Way, Laurel MD 20724 Baltimore, MD (Son) Christopher Grayton 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Department of Important: I 5/13/2009 Hanover, Maryland Ardent Crematory Donation 5 Other Specify: 22. Name and Address of Facility Latimore Funeral Services, P.A. 21. Signature of Funeral Service Licensy 9013 Annapolis Road, Lanham MD 20706 alimore Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician 'M dical failure. List only one cause on each line. Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine Cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical ned by the attending physician a detached for use as the burial -AMENDED UNPENDED 23d. Date of delivery Box 68760, 23c. If ves, outcome of pregnancy IF FEMALE: Year Day 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the past 12 months? Fetal death Live birth 2 Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown q 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the detache Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown φ 24b. Were autopsy findings available Completed 24a. Was an page 2 should prior to completion of cause of autopsy death? performed' this certificate has 1 🗸 Yes No ✓ Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Division of Vital Be Other<sub>4</sub> Residence 6 Nursing Home 5 examiner? Inpatient 2 V ER/Outpatient 3 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After t 27. Manner of Death Certification: Yes 2 No 1 V Natural thin 24 hours after death.

the Funeral Director: A Pending 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the 1 and manner state 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier May 7, 2009 O.C.M.E. OCME m 30. Name and address of person who completed suse of death (Item 23a) By 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. Assistant Medical Examiner 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Golfo A. Haralampopoulos 9:15 a 2009 Mav /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) Montgomery Silver Spring 1211 Magnolia Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🕱 F 1924 Greece 84 215-58-8350 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show event, the Medical Evaninar must be notified at 1 ☐ Yes 2 🕱 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō with Greece 20905 "natural", or items 23a 1211 Magnolia Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 👿 No If Yes, Give Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, It all College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia Mandes Konstantine Stratigis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) -Son 1211 Magnolia Road, Silver Spring, MD 20905 Konstantine A. Haralampopoulos 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 12, v Injury on Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2009 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd., W, Silver Spring MD 20901

Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respiratory Arrest /Medical resulting in death) Due to (or as a consequence of): Examiner 3 minutes Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Atherosclerotic Heart Condition Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Live birth 2 Fetal death Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 2 No 1 ☐ Yes 2**5** No 1 ☐ Yes certificate after death.

Director: After this certific 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ₹ No Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

within 24 hours aft

To the Funeral Di

completely filled in

State Registrar

Medical

29a. Certifie

(Check only one)

29b. Signature and title of certifier

J. Benjamin Untivered mo 8903 Shady Grove Court, Gaithersburg, MD 20877 32. Fegistrar's Signature

yourse Cho livers 14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darke

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D28671

29d. Date signed (Month, Day, Year)

Nay, 07, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 and 26 per phys G891 5/29/09 dk.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year **Physician** 17:10 May rlene Harrison 10 2009 /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore of Maryland University Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 4 F Months Days Hours Min. 218-32-6034 73 Director January 21, 1936 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28e-f show eny Injury or other traumetic event, Ihn Medical Examiner must be notified at 1 □Yes 2 □ No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Edenton Lane 21629 United States of America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Caucasian Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Edward Kreiner Martha Agnes Rowan James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Harrison 105 Edenton Lane, Denton, Maryland 21629 Husband 20b. Place of Disposition (Name of cemetery, crimatory or other place)
Maryland Lastern Shore
Veterans Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/2009 4 Donation 5 Dother (Specify) Beulah, Maryland 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland Signature of Funeral Service L nous 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Preumonia Acineto bacter disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Renal Failur Sequentially list conditions, Examiner day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coagnlation Disseminated Intravoscular burial-trar Due to (or as a consequence of) physician Box 68760, Physician/Medical the as attending IE FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Year P.0. detached 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Pulmonary Fibrosis 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Chronic autopsy eg d performed? 1 ☐ Yes 2 ☑ No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 24 hours after death.

Funerel Director: After this 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 □Yes 2 □No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD AU4176435 P18986 May 2009 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Phelan

Timethy

31. Date filed (Mghth, Day, Year)

22

32. Registrar's Signature

S.

H.

Greene St.,

Bultimore, MD

2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 18:18 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HICOMICO 30/15414 GANAL DUBL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🖫 F Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. Count 10a. State 28a-f show or than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Neyer Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ISLAND ROAD VIENNAMO 21869 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smertists Course (Final) Name and Add Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VV **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of) physician aftending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month ō 5 ☐ Other (specify) ed by the a o. 9 Unknown 9 Unknown ۵. s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Karktnam 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2**2**No 1 ☐ Yes 1 ☐ Yes Vital Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1**Y**OYes 2 □ No 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To of 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27, Manner of Death 1 Natural
2 Accident (Month, Day, Year) Injury Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of 8109

Registrar

State

100

Carroll

R.M.C

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

State of Maryland / Department of Health and Mental Hygiene

			_ FOF	ertificate of Death		eg. No.
	Physici	an	Decedent's Name (First, Middle, Last)  JOSEPH EUGENE HETM		2. Date of Deat Month <b>MAY</b>	8 2009 3. Time of Death 9:15 A.M
The same	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death
			920 THOMPSON CREEK ROAD  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	STEVENSVILLE  July If Under 1 Year   If Under 24 Hrs	8 Date of Birth	QUEEN ANNE'S  9. Birthplace (State or Foreign
Ь	Funeral Director		150-24-0365 <sup>1</sup> X M 2□ F 80 Yrs	Months Days Hours Min.		1928 MARYLAND
	fand		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	e Mary Ba-f sh	ctor	MARYLAND QUEEN ANNE'S STEVEN	SVILLE		1 □Yes 2 <b>X</b> No
	with th	Funeral Director	10e. Street and Number  920 THOMPSON CREEK ROAD	10f. Zip Code <b>21666</b>	1	0g. Citizen of What Country?  UNITED STATES
	ems 2;	nera	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	Was Decedent of Hispanic Origin? (     If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
936	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at		1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 1 ▼ Yes 2 □ No If Yes 3 ■ 47-1950 Year or Dates:	1 ☐Yes 2 X No Specify:		Specify: WHITE
21215-0036	72 hor	Completed by	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of wo e. DO NOT use retired)	orking	16b. Kind of Business/Industry
212	e filed within al Hygiene. I other than ' went, I've We	dwo		VATERMAN		SEAFOOD
	be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last)  JOSEPH HEIM		me (First, Middle, I	
Maryland	2 should be and Mental is marked aumatic ev	ပ		ailing Address (Street and Number or F	INE HASPE	
	1 and 2 s Health a em 27 is					ENSVILLE, MD 21619
Baltimore,	S to the		1 ■ Burial 2 □ Cremation 3 □ Removal from State WCODLA	sposition (Name of Name) ARK		20c. Location - City or Town, State  EASTON, MARYLAND
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Euperal Serue Licensee	FELLOWS, HELFENBE 106 SHAMROCK ROAD	IN & NEWN	AM FUNERAL HOME, P.A.
			23a. Part 1. Her Hing Line, or complications that it used the death. Do not shock, or heart failure. List only one cause on each line.			
d	Physician		Immediate Cause (Final disease or condition resulting in death)	rer		Onset and Death 22 man ThS
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	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events c.			
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68760,	ate be ohysicia the bur	Medical	d			
9 xc	certific nding p ise as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	* de		23d. Date of delivery
P.O. Box	Physician: The law requires that the death cer this certificate has been signed by the attendin al director, page 2 should be detached for use	Physician/P	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
Is, P	es that igned b		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	100	bacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 □ Unknown
cord	w requires s been sign should be	eted			24a. Was a	
Vital Records,	The law cate has page 2 :	Completed by	Thoracia Ko-til Kneurgin		autops perfor	sy prior to completion of cause of death?
/ital	nysician: The	Be	25. Was case referred to medical examiner?	Othori	eath (Check only or	ne)
	Physical direction	5.T	1   Yes 2 No   Hospital: 1   Inpatient 2   ER/Outpa 27. Manner-of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at		ence 6 ☐ Other (Specify) ow injury occurred
ion	Attending Phy or death. ector: After thi by the funeral of	ation	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Inju 2 ☐ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No		
Division	al or Attendi after death. I Director: A d in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, decided in the past of examination and/of and manner stated.	eath occurred at the time, date and pla or investigation, in my opinion, death occ	ce, and due to the courred at the time, co	cause(s) and manner as stated. date and place, and due to the cause(s)
4	Vithir vithin Comp	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)
	441		The Have my	04,339		05-98-2009
	MS		30. Name and address of person who completed cause of death (Item 23a) (Ty  JANIE HARMS MO 115 SALLITS OR	IVE STEVENSVILL	E MO	21666
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	barrel	(	
	Regist	ali	MAY 11 2009 Lehous B. 4	Park		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** May 2009 6:45 AM Alonzo A. Hubbard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 936 Bay Ridge Avenue, #106 Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 2, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** <sup>Year)</sup> 1929 Months Days Hours Min. XXM 2 F 80 217-24-6380 Maryland **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Maryland Anne Arundel Annapolis ns 23a or 28a-f si must be notified Director 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 936 Bay Ridge Avenue, #106 21403 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status other traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 □Yes 2 ☑ No Specify Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Sergeant U.S. Air Force 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alonzo Hubbard Agnes Trew ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenny Hubbard/wife 936 Bay Ridge Avenue, #106 Annapolis, MD 21403 Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ŏ 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or Atlantic Crematory 5/9/2009 Glen Burnie, Maryland 5 ☐ Other (Specify) 4 Donation Service Licenses 21. Signature of Funeral 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Prostate Cancer 18 months /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>δ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 No 1∐Yes 2x2No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 反 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Plospital or Attending Plant Plours after death.
Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature e of certifie 29c. License number D65272 5/7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Road, Suite 300 Annapolis, MD 21401 Jason Taksey 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Denn S. parl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) PM **Physician** 5:25 2009 Ruth Marie Holden May 8, /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Cheverly Prince George's Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M 2 🖾 F 578-70-7998 74 Yrs. December 18,1934 Danville, Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Wedical Examinar is just by notified at 1 X Yes 2 □ No Director Marvland | Prince George's Brentwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number e filed within 72 hours after death with tal Hygiene. other than "natural", or items 23a or ? 20722 USA 3701 Quincy Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be filk of Health and Mental H Fitem 27 is marked oth r other traumatic even Be Alice Blankenship Ammon Franklin Tuck ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2: 3825 37th Place, Brentwood, MD 20722 Vita G. Coman / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland Fort Lincoln Cemetery 5/15/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 mon leno 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bleedin **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 5005:5 w:th Klebsiella Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner zynemic physician and the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month in the past 12 months? 5 Other (specify) I∐Yes 2 X No ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 D No has 2 No certificate 1 □ Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury Certification: After 1 (Month, Day, Year) 5 Pending investigation 1 X Natural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined

the death certificate be executed Box 68760, o ٣. Records, Division of Vital ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t completely filled in by the

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2.

Medical

29b. Signature and title of certifier In. Bodelia

29a. Certifier

(Check only one)

29c. License number 18887000 29d. Date signed (Month, Day, Year)

onve Cheverly

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 Kemil Abolella, MD

State Registrar

2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NES /Medical County of Death Facility Name (If not institution, give street and num 4b. City, Town or Location of Death **Examiner** PRINCE GEORGES KIVERDAL ENTER ITIES If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 🖡 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County MASHINGTON Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20009 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2.5 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OCKROOM other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OWNSEL ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Prin 9102 VARNUM ST. CANHAM, MD 26706 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o **2**□ Cremation NOOLN MEMORIAL WIRAND, MO 5-13-09 5 Other 22. Name and Address of Facility JOHN RHINES FUNERAL HOME Signature of Funeral Service 3005 12TH STREET N.E. WASH. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. a. Part1. Enter the disea e, or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Anterioscherotic Cardiovascular Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last

or Attending Physician: The law requires that the death certificate be executed

Physician/Medical Examiner Be Completed Medical Certification: To

Division of Vital Records, P.O. Box 68760,

9 21 21 21	23b.
5	Part I
3	

IF FEMALE: Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If	ves. c	utcom	e of p	reana	ncv
- 1		e birth	2 🗆	l Fetal	de
	= -				

ath Pregnant at time of death

Due to (or as a consequence of):

Due to (or as a consequence of)

3 🗆 Ectopic pregnancy 5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

> 23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes

24a. Was an autopsy performe 21, 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 ☐ Yes

10d. Inside City Limits

U.S.A

BIAC

1 Nes 2 No

DC 20017

4-20,25

Year

examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Mursing Home 5 Residence 6 Other (Specify)
7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	м	8c. Injury at Work? 1 □ Yes 2 □ No
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	, office 28f. Location (Street and Number or Rural Route Numb City or Town, State)

1	29a. Certifier
ı	(Check onl)
Į	one)

25. Was case referred to medical

and manner stated. 29b. Signature and title of certifier

101852

1 | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print)

Jecusbury 2d Hyattsville MD 20781

State Registrar

completely

after death Director:

within 2 To the I

		1	For State Registrar	State of Maryland		rtment of H tificate of L			eg. No.	9 16795
Physi			Decedent's Name (First, Middle, Last)	HAE	RTWE	i.(_		2. Date of Deat Month	h Day Ye	
/Med Exam			a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or			4c. County of D	
		-	WASHINGTON A . Social Security Number 6. Sex	7. Age (In yrs. In		Takoma If Under 1 Year	Park If Under 24 Hrs.	8. Date of Birth	Montg	Birthplace (State or Foreign
Funera Directo	_			M 2□F 88	Yrs.	Months Days	Hours Min.	Feb. 9,	Year) 1921 No	orthfork, WV
land ow		-	Usual Residence of Decedent  0a. State 10b. County	10c. City	y, Town or Loc	ation				10d. Inside City Limits
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ith the	Director	1	0e. Street and Number			10f. Zip Code	701	1	0g. Citizen of What	: Country?
eath w	Fineral	3 1	5509 40th Avenue  1. Marital Status	. Was Decedent Ever in U.S	S. 13. W	/as Decedent of H Yes, specify Cuba	781 ispanic Origin? (S	pecify Yes or No-		American Indian,
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. It Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exemination at the modified at	3	2	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII	١,	Yes, specify Cuba  ☐ Yes 2☑No		o Rican, etc.)	Specify:	/hite, etc. Black
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Pages ment of lant: If ite			1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	lemoria	atory or other place g Green I Garden	1 3 / 12	2/2009	Camp Hil	l,Pennsylvania
permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other	SUCE SUCE	1	21. Signature of Funeral Service Licensee	Money		Name and Addre	GI	lbert L.	Dalley F sburg, PA	Uneral Home 17103  Approximate Interval Between
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juires that n signed b ild be deta	ž	ן בֿ	Part II. Other significant conditions cont	ibuting to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.			ite to the cause of death?  ☐ Probably 4 Unknown
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending completely filled in by the funeral director, page 2 should be detached for use a		naialdillon a	25. Was case referred to medical				26. Place of De		med? dea 2 No 1	re autopsy findings available ir to completion of cause of th? IYes 2 □No
hysicia his cer I direct	F G	۱۵	examiner?	spital: 1 ☐ Inpatient 2 ☑	ER/Outpatien	it 3 □ DOA Oth	or:		dence 6 ☐ Other	(Specify)
ling Pl		<u>i</u> i	27. Manner of eath 1⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ryat k?  Yes 2. □No	28d. Describe h	now injury occurred	
after death Director:	Cortification.	ermear	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre fy)		11es 2 🗆 140	28f. Location (S City or Tou	Street and Number vn, State)	or Rural Route Number,
ospita hours ineral ly filled	O legipol		29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the ti vestigation, in my	me, date and place	e, and due to the curred at the time,	cause(s) and manr date and place, and	ner as stated. d due to the cause(s)
<b>포</b> 42 년 현		٠,		and marrier stated.		00- 11	o number		29d. Date signed (	Month Day, Year)
To the Hovithin 24 of the Fu	Mod	ž	29b. Signature and title of certifier			29c. Licens	se number	1		
	Mode	M	. 11	v D.O.		67	613		05-0	2-2009
To the Howittin 24 vittin 24 To the Fu complete	Now		. 11	npleted cause of death (Iter	m 23a) (Type,	67	613		05-0	2 - 200°1

#### State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Chet Howard 2009 /Medical May 6. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 9. Birthplace (State or Foreign Country) Southern Maryland Hospital Clinton r | If Under 24 Hr Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1**☑** M 2□ F 66 Yrs. Months Days 386-44-2938 Director May 9. 1942 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral", or items 23a or 28a-f shov Director PG MD Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5825 Barnes Drive 20735 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 2 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Unk. Unk. Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health and Important: If item 27 Is m any Injury or other traum once. 5825 Barnes Drive Clinton, Md 2073 20b. Place of Disposition (Name of cemetery, crematory or other place) Patricia Howard/wife 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem. 5/13/09 Clinton, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee β910 Silver Hill Řd., Suitland,MD.20746 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. miscliate Cause (Final **Physician** Atheroselevine Cardiovanum diseane disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** GI Acule upper Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 2 00 1 ☐ Yes Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Division 1 Accident 1 ☐ Yes 2 ☐ No illed in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10:50A

11☑Yes 2 No

Year

29d. Date signed (Month, Day, Year)

05/06/2009

SHWELT RD Clinton ND 20731

State Registrar

5. By

DHMH 17 Rev 1/2001

Southern

> Anif k ma Lougin mD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

may and treptal conten 7503

32. Registrar's Signature

and manner stated.

**ORIGINAL** 

29c. License number

D50689

ANIL K MAHAJAN MD

			For State Registrar	State of M	aryland	d / Depa <i>Cei</i>	artment of rtificate of	Health a	ind Mer		ene () ()	19	16797
	Dhyaisi		1. Decedent's Name (First, Middle	, Last)					2.	Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		BERTHA	JE!	NNING	S				AY 7	2009		9:00 A M
*	Examin	er	4a. Facility Name (If not institution	-	)		4b. City, Town,		f Death		4c. County		
20.5			PRINCE GEROGE 5. Social Security Number		ge (In yrs. la	et hirthday)	CHEV	VERLY	24 Hrs. 8	Date of Birth	PRINC		ORGE 'S
	Funeral Director		245-38-8153	1∭ M 2□F	96 ( <i>III yi</i> 5. 16	. V	Months Days		Min.	(Month, Day, UG 18		Coun	H CAROLINA_
			Usual Residence of Decedent				1			.00 10			
f	show	_	10a. State 10b. County		10c. City	, Town or Lo	ocation					1	0d. Inside City Limits 1 □ Yes 2 □ No
	Ba-f.	cto		E GEORGE'S	UPI	PER MA	RLBORO			1.0	g. Citizen of V	15-24 0-11	
	with the Cor. 2 De Co. 2	ă	10e. Street and Number				10f. Zip Code					mat Cour	iuy :
	eath v	erai	13000 FOX BOW	DRIVE 12. Was Decedent	Ever in U.S	3. 13.	2077 Was Decedent of		gin? (Specif	v Yes or No-	USA 14. Race	e - Americ	can Indian,
<b>.</b>	fter d	by Funeral Director	1 □ Never Married 2 □ Marr	Armed Forces?	?		If Yes, specify Cu	iban, Mexican,	, Puerto Ric	an, etc.)		k, White,	
21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or fleme 23a or 28a-f show the Medical Examinar must be notified at	Ď	3  Widowed 4 □ Divorced	If Yes, Give			1 □ Yes 2√∏ N	o Specify:			Specify	· BLA	.CK
5	72 ho natur licat	Completed	15. Decedent (Specify only highes	t's Education st grade completed)		(Give	dent's Usual Occ	e during most	t of working	1	6b. Kind of Bu	isiness/ln	dustry
2	Althin De.	щ	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retir	red)					
Ċ K	iled v Tygie ther t	ပိ	12th 17. Father's Name (First, Middle,	l ast)		CUST	ODIAN	18. Mothe	r's Name (F	First, Middle, M		ERNME	NT
Maryland	antal h	Be	BOYD BEASLEY	220.7				MAR		TT		,	
<u></u>	shoul mark mati	၉	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Stree				City or Town,	State, Zip	Code)
Ž	nd 2 :		GLORIA D. JOHN	SON/DAUGHTE	R								ND 20774
Je,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Any injury or other traumatic event, the Madical Examinat must be notified at any injury or other traumatic event, the Madical Examinat must be notified at any injury or other traumatic event, the Madical Examinat must be notified at any injury or other traumatic event, the Madical Examination.		20a. Method of Disposition		1 00	ace of Disponentery, cre	osition (Name of matory or other p	iace)	Date	9 2	Oc. Location -	City or To	own, State
Baltimore,	Page nent c nnt: if ury or		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		9	•	LL CEMET		5/12/2	009	SUITLAN	ID, MA	RYLAND
ati	permit. Departr Imports any inju		21. Synature of Furleral Service	icensee		2	2. Name and Add			B. JENI			
_	207 2 9		Cry q	<u> </u>			7474 LAI					LAND	
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each !	ed the death line.	. Do not en	ter the mode of d	ying, such as	cardiac of r	espiratory arre	st,		Approximate Interval Between Onset and Death
dĒ.	Physician		Immediate Cause (Final disease or condition resulting in death)	a	NGEST	LVE HE	ART FAII	LURE					
	/Medical Examiner		rosulting in assum)	Due to (or as	s a consequ PERTEN								
		e.	Sequentially list conditions if any, leading to immediate	Due to (or as									-
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G									
oʻ	ate be executed hysicien and he burial-transit	Exa	resulting in death) Last	Due to (or as	s a consequ	ence of):						==1	
	ate be hysici he bu	lical		d									
89 x	death certifical e ettending phy id for use as th	Physician/Med	IF FEMALE:	220 Hugo cutom	o of prognati		2 (22)						
Вох	sath c ettenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 🗌 Fetal	death 3	□Ectopic pregnar □ Other (specify)					te of deliv onth	Pery Day Year
o.	0 0 0	ysic	1 ☐ Yes 24 No 9 ☐ Unknown	9□ Unknown	at time or de	Jan 31	_ Cities (apociny)						
<u>a</u>	The law requires that the the law sequires that the seen signed by the page 2 should be detache	by Ph	Part II. Dther significant condition	ons contributing to death	but not resu	ulting in the u	underlying cause	given in Part I.		23e. Did tob	acco use cont	ribute to t	the cause of death?
rgs	quires t in signe uld be		RHEUMATOID A	RTHRITIS						1 □ Ye	s 2 🗆 No	3 Pro	bably 4XDUnknown
ပ္တ	e law requir has been si je 2 should	Completed	ANEMIA							24a. Was an	24b.	Were auto	opsy findings available omptetion of cause of
Vital Records,	The I	E	RESPIRATORY	FATLURE.						perform 1 ☐ Yes 2	ned?	death? 1 🗌 Yes	2√∑ No
/ita	elcien: Th certificete rector, pag	Be (	25. Was case referred to medica examiner?	1					of Death (	Check only on	9)		
ot o	Phyelcien: this certific ral director,	၉	1 ☐ Yes 2 TNo				HIL SUDOA			5 Reside			rfy)
	Jing After fune	ion	27. Manner of Death 1 □ Natural 5 □ Pendir		ay Year)	28b. Time of Injury	N V	ljuryat Vork? □Yes 2□		d. Describe ho	w riquity occur	160	
Division	l or Attending after death. Director: After I in by the funer	licat	2 Accident investi 3 Suicide 6 Could	not be 200 Place of Ir	niury - At ho	me, farm, s	treet, factory, offic					ber or Rui	ral Route Number,
É		Certification;	4 ☐ Homicide determ	building, e	etc." (Specify	()	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town	, State)		
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in		29a. Certifier 1 Certifyin	ng Physician: To the bes	t of my kno	wledge dea	th occurred at the	time, date an	nd place, an	d due to the ca	ause(s) and ma	anner as	stated.
	he He in 24 he Fu	ledicai	(Check only 2 Medical one)	Examiner: On the basis and manner s	stated.	lion and/or i			ath occurred				
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	100111	ut	1/2	20e. Lice	ense number		2!	9d. Date signe	a (Month,	Dey, Year)
	6					9		16273			0/	_/	
	8		30. Name and address of person REVATHY MURT					JEWEDT V	7 MADS	TAND	20785		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture	R ROAD CH	LEVEKLY	, MAKY	LAMU .	20705		
	Regist		WAY 1 1 2009	Genera D.	pa	Kel							

**Physician** /Medical Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Completed Be Medical Certification: To

24b. Were autopsy findings available prior to completion of cause of death? 1 ∐Yes 2 🔀 No 1 ☐ Yes 2 1No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Beath 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1.☐ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

0060100

AUmto

State Registrar

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-03914	
Gloria Jenkins	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 16799

		I- For State Registrar			Ce	ertifica	te of i	Death				F	Reg. No			
Physicia Medical Exami	ın/	1. Decedent's Name	(First, Middle	JENKI	NS							Date of Dea Month May 16, 2	ath Day	Year		3. Time of Death 2110 hrs
		4a. Facility Name (if r		n, give street and no			46	. City, To Lanhar		ocation of		<u> </u>	4	c. County of Prince G		s
Funeral		5. Social Security Nu		6. Sex	7. Age (In yrs	. last birth	day)	If Under	1 Year	If Under	24Hrs.	8. Date of B	irth(MM	/DD/YYYY)		place (State or
Director		195-40-2		1 M 2 X F	59		Yrs.	Months	Days	Hours	Min.	11/21	/19	/ <sub>1</sub> Q	Foreigr Cou	ntry) PA
	ŀ	Usual Residence of D		- (44)								11/21	/ I J	<del>-</del> -		
v any		10a. State 10	0b. County	<u> </u>	10c. Cit	ty, Town o	r Locatio	n								10d. Inside City Limits
daryland 28a-f show any <u>dat once,</u>	5	MD Prince Georges Hyattsville  10e. Street and Number 10g. Citizen of													1 Yes 2 X No	
th the Maryland 23a or 28a-f sho	Director						į						10g. Ci		at Coun	ry?
ith the 1 23a or notifie		8812 Ste	rling		cedent Ever in	116	13 14/00		785	anio Origi	n2 / Sne/	cify Yes or N	lo.	USA	- Americ	an Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland mtal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	Never Married	2 Ma	rried Armed F	orces?							ican, etc.)		White		an malan, 2.00m,
ifter de	by Fi	3 Widowed	4 X Divo	orced If Yes, Give Ye or Dates:	2 X No ar		1 `	Yes 2	No No	specify:				Specify:	B1a	ck
nours a		15. Decedent's Edu		ify only highest gra		16a. C		s Usual C					16b.	Kind of Bus	siness/Ir	dustry
36 in 72 h han "r lical E	Completed	Elementary/Secon	dary (0-12)	College (	1-4 or 5+)			al R				-,	DI	weici	200	Office
d with d with giene ther the	E	12th 17. Father's Name (F	irst. Middle.	Last)		ľ	learc	al K				First, Middle,		-		OTTICE
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Bec	John Jac										ackson				
Ze mage		19a. Informant's Nam		nip (Type, Print )		19b	. Mailing	Address			-	rai Route Nu		City or Towr	n, State,	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner.				-Brother-				Ster1				ttsvi				
of Her		20a. Method of Dispo		3 Removal f	rom State		ry or othe	er place)		,		Date		. Location -	City or	rown, State
Fagurent tant:		4 Donation 5	Other Sp		H	armor						-2009		andove	_	MD.
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Fund	eral Service I	Licensee	)		Mar	sha1	ddress c	Fune	ral	Home Suitl	of N	Maryla	and	46
Physician	$\dashv$	23a, Part I. Enter the			caused the dea	th. Do no										Approximate Interval
/Medical	ļ	failure. List only Immediate Cause (Fi		on each line. a. <u>Athero</u>	sclarat	ric c	ardi	ovas	cu1 a	r di	Seas	P				Between Onset and Death
xaminer		or condition resulting			a consequence		arur	OVGD	cara	1 41	beab					
	<u>.</u>	Sequentially list condif any, leading to imn		b. Due to (or as	a consequence	e of):	_						_			
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executed an and al - transit		events resulting in de	eath) Last	Due to (or as	a consequence							·				
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8760, tificate be ng physici as the buri	/Me	IF FEMALE: 23b. Was decedent p	regnant in th		outcome of pr			al death	3	Ectopic	pregnan	CV	2	3d. Date of Month	,	ay Year
Se de Ge		past 12 months?		4 Preg	nant at time of	death 5		al death er (Spec		Ectopic	pregnan	Су	1	Month		ay Teal
Box e death c the atten	Physicia	1 Yes 2 ✔ No		nown g Unkr												
Records, P.O. Box E The law requires that the death ce cate has been signed by the attend page 2 should be detached for use	þ	Part II. Other signifi	cant conditi	ons contributing	to death but no	ot resulting	in the ur	nderlying	cause giv	ven in Par	rt I.					the cause of death? ably 4 🗹 Unknown
ds, require	Completed									-		24a. Wa				topsy findings available
2 8 8 2	<u>d</u>	-											opsy formed	?   c	leath?	ompletion of cause of
		25. Was case referre	ed to medical	1				2	6.Place o	of Death (	Check or		,	140		2 10
Vital   hysician: this certif	o Be	examiner? 1 ✓ Yes 2	No	Hospital: 1	Inpatient 2	ER/Qu	utpatient	3 D	DA C	Other4	Nursing	Home 5	Resi	dence 6	Other	: Scene
	Ë	27. Manner of Death		28a. Dat (Mon	e of Injury h, Day,Year)	28b. 1	Time of In	ijury 2		at Work		28d. Describ	e how i	njury occurr	ed	-
Sion Vittend death. ctor:	atic	1 Natural 2 Accident	5 Pend Inves	tigation				-		es 2			(0)	<u>-</u>		(B) (A) (A)
Division pital or Attendiours after death. reral Director: A	Certification:	Galeide		d not be 28e. Pla mined (Specify	ce of Injury - A	t home, fa	rm, stree	t, factory,	office bu	iilding, etc	. 1	or Town		t and Numb	er or Ku	ral Route Number, City
lospit 4 hour unera		4 Homicide 29a. Certifier		nysician: To the be		edge, des	th occurr	ed at the	time, dat	e and nia	ce, and r	due to the ca	iuse(s)	and manner	as state	ed.
Division  To the Hospital or Attent within 24 hours after death To the Funcral Director:	Medical	(Check only one) 2 V	Medical Exa	miner:On the basis and manner	of examination	n and/or ir	rvestigati	on, in my	opinion,	death occ	curred at	the time, da	te and p	olace, and d	lue to th	e cause(s)
F 3 F 3	Me	29b. Signature and ti	itle of certifie				•	29c	License					-		nth, Day, Year)
		( l ai	Lal	lealth)					O.C.N	1.E.			M	ay 17, 20	009	
n		30. Name and addre			,		Dem	Ctront	Daltir-	oro Mai	D 2420	11				
		Laron Locke		ssistant Medic	al Examine Registrari Sign			Street,	minisa	iore, Mi	2120					
St	ate	31. Date filed (Month	, vay year)	<b>▲</b> 32. F	regional Sign	au e										

09-03619 Stephanie L. Kitt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 16800

,		For State			Certific	cate of	Death				R	eg. No.				
Physician/	1.	Decedent's Name (First, Midd									Date of Dea Month	Day	Ye	ar	3. Time of De 1631 hr	
ledical Examine		STEPHANIE				KITT	b. City, Tov	n orl	ocation of		May 5, 20		. County	of Deat		
	4	a. Facility Name (if not instituti Suburban Hospital	on, give street and	number)		41	Betheso		Cation of	Death			/lontgo			1
Funeral	5	. Social Security Number	6. Sex	7. Age (In	yrs. last b	oirthday)	If Under	Year	If Under	24Hrs.	8. Date of Bi	rth(MM/	DD/YYY	Y) 9. Bi	rthplace (State	or NCTON
Director		577-82-4657	1 M 2 X	3	6	Yrs.	Months	Days	Hours	Min.	DEC 1	2 19	972	Co	ountry)	DC .
any	_	Isual Residence of Decedent  0a. State 10b. County	,	100	c. City, Tov	vn or Locatio	on								10d. Inside	City Limits
* .	1		TGOMERY			JRTONS									1 X Yes	2 No
Aaryland 28a-f show 1 at once.	1	0e. Street and Number					10f. Zip C	ode				10g. Citi	izen of W	√hat Cou	untry?	
the Maryland a or 28a-f sh iffed at one		4330 ISLESWOO	D TERRACI	E			2	086	6		1	USA	A			
h with to ms 23a be not		Marital Status	12. Was [	Decedent Eve	er in U.S.	13. Was	s Decedent es, specify	of Hisp	anic Origi Mexican	in? (Spec	cify Yes or N	0-		ce - Ame ite, etc.	rican Indian, B	lack,
r death with the Maryland or items 23a or 28a-f sho must be notified at once			1 Ye		No					T GOILD I	, , , , , , , , , , , , , , , , , , , ,	Ì	0		BLACK	
1	<u> </u>	3 Widowed 4 XD  15. Decedent's Education (Sp	ivorced If Yes, Give or Dates:		16	a. Decedent	Yes 2 X			ind of wo	rk done	16b.	Specify Kind of E		JLAUN s/industry	
be filed within 72 hours after death with the Maryland mal Hygiens rived other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once the formal Acad by Elimoral Director		15. Decedents Education (Sp Elementary/Secondary (0-12		e (1-4 or 5+)	10	during mo	ost of worki	ng life.	DO NOT	use retire	d)					ŀ
36 hin 72 than than	naialdiio	Elementary/observatry (5 12	′	YRS		EXE	CUTIV	E	ASSI	STAN	Γ	G	OVER	NMEN	ITT	
5-00 ed wit fygien other		7. Father's Name (First, Middl	e, Last)					1		,	First, Middle,	Maider	n Surnan	ne)		
21215-0036 Juld be filed within 7 Mental Hygiene marked other than ic event, the Medica			LEWIS						MYR		KITT	. mala as C	City or To	own Sta	ite, Zip Code)	
AD 21 2 should the and Me 27 is man immatic ev	2   1	19a. Informant's Name/Relation			71										ARYLAND	20866
- p = e =	ŀ	ERITA KITT/ 20a, Method of Disposition	SISTER_	_	20b. Plac	ce of Dispos	ition (Name	_			Date				or Town, State	
Ore ges 1 a r of H r of H	- 1		on 3 Remov	al from State		matory or oth		EME	TEDV	5/1	5/2009		TTNT	'ON . I	1ARYLAN	D
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other 21. Signature of Furera	Specify: e Llou see		KES		Name and A			J.	B. JE	NKI			RAL HOM	
Balt permit Departi Importi injury		4	V		_	74	474 L	ANDO	VER :	ROAD	LANDO	VER	,MAR	YLAN.		
Physician	1	23a. Part I. Enter the disease, failure. List only one caus	or complications th	at caused the	e death. Do	not enter t	he mode of	dying,	such as ca	ardiac or	respiratory a	rrest, sh	hock, or I	neart	Between	ate Interval Onset and
'Medical .aminer		Immediate Cause (Final disea	se a. Pulmona	ary Throm	boembo	olism									B	eath
, anniet	1	or condition resulting in death)	Due to (or	as a consequ	uence of):											
1	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequ	uence of):											
	E١	cause. Enter Underlying Caus (Disease or injury that initiated	D	as a consequ	ience of):			_							-	
ted 1 msit		events resulting in death) Las	t Due to (or	as a consequ	derice or).											
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68760, certificate be executed nding physician and se as the burial - transit		IF FEMALE:		es, outcome	of pregnar	ncy						2	23d. Date		,	Year
Sox 687  Jeath certific  e attending    for use as t		23b. Was decedent pregnant in past 12 months?	'	ive birth regnant at tir	ne of death		etal death ther <i>(Sp</i> ec		Ectopi	c pregnar	тсу		Month	1	Day	Teal
Box e death c the atten	Physician	1 Yes 2 V No 9	lelie euro	nknown		3 0	ther topeo									
O. B nat the date of by the ctached		Part II. Other significant con	ditions contributi	ng to death t	out not resu	ulting in the	underlying	cause (	given in Pa	art I.					to the cause of	
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Cecc	Completed by	1										s 2		1 🗸		No
Vital Recc ysician: The lav his certificate ha director, page 2	Be	25. Was case referred to med examiner?							of Death Other;			70	idence	6 0	ther:	
Physic Physic al dire	인	1 ✓ Yes 2 No	Hospital:	Date of Injury	, 12	R/Outpatien		AC Iniu	ry at Wor	·k?	g Home 5 28d. Descril	be how i	injury oc	-		
on of \ ending Phy sath. or: After the			ending FO	Vonth, Day, Yes JND: 5, 2009	ar)	UNKNOWI			Yes 2 🗸		Subject ir	njured	toe			
Division of Vital Records, P. spital or Attending Physician: The law requires th hours after death.  meral Director: After this certificate has been signe y filled in by the funeral director, page 2 should be de	Certification:	3 Suicide 6 C	ould not be 28e.	Place of Inju		ne, farm, stre	eet, factory	office !	ouilding, e	- 1		n (Stree n, State)		ımber or	Rural Route N	Number, City
spi nou ner	ca Ca	29a. Certifier	Physician: To the	e best of my	knowledge	e, death occu	urred at the	time, d	ate and pl	lace, and	due to the c	ause(s) ate and	and mar	nner as s	stated. to the cause(s)	
Som Tarking To the state of the	Medical	29b. Signature and title of ger	and man	ner stated.					se numbe						(Month, Day, Y	
	-		1- 110	)				O.C.	M.E.			M	1ay 6, 2	2009		
7		0. Name and address of per	son who completed	cause of de	ath (Item 2	23a)										
	İ	Laron Locke MD.	Assistant Me			111 Pen	n Street	Balti	more, N	MD 212	01					
Sta		31. Date filed (Month, Day, Ye	00	2. Registrar	s Signatur	factor	1									
Registr	_		NO CHAP	- J	7											
DHMH 17 Rev 1/20 OCME 2006	101	OC	ME			ORIGIN	AL									

09-03632 Theodore Karnezis

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 1680	2	0	0	9			6	8	0
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		1- For State Conversion 1 - For State Conversi	Reg. N	No.	
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Theodore Karnezis	2. Date of Death Month Da May 6, 2009	ay Year	3. Time of Death 0920 hrs
₹		4a. Facility Name (if not institution, give street and number)  Southern Maryland Hospital  4b. City, Town, or Location of D  Clinton	eath	4c. County of Death Prince George	's
Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1 If Under 1 Year If Under 24 Months Days Hours  Usual Residence of Decedent	Min. March 2	MM/DD/YYYY) 9. Birt Foreig 2,1947 Cou	
nd show any nce.	٦٢	10a. State 10b. County 10c. City, Town or Location 10a. State 10r. County 10c. City, Town or Location 10c. City, T			10d. Inside City Limits  1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 7501 Earnshaw Drive 10f. Zip Code 20613	10g.	Citizen of What Cour USA	itry?
er death with , or items 2 r must be n	Funeral	11. Marital Status  1 Never Married  2 Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  3 Widowed  4 Divorced If Yes, Give Year  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No		14. Race - Ameri White, etc. Specify: Whi	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Markel Mygere in the material", or items 23a or 28a-f she limportant: If tiem 27 is markel other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	leted by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	e retired)	b. Kind of Business/I	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be Completed	2 Oonstruction Supervi	Iame (First, Middle, Maid	Pepco den Surname) Vodor	ins
MD 212 d 2 should be tht and Ments n 27 is mark tumatic even	ToB	19a. Informant's Name/Relationship (Type, Print) Freddi Angela Karnezis- Wife 7501 Earnshaw Dr.,	r or Rural Route Number Brandywine	r, City or Town, State	, Zip Code)
Baltimore, leemit. Pages I and Department of Heal Important: If item injury or other tra		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Kalas Crematory	5/12/2009	Oc. Location - City or Edgewater	, MD
Balt permit. Depart Import	6 10	21. Signatur Funeral Service Licensee  22. Name and Address of Facilit Ge  160 Oxon Hill Rd	l., Oxon Hil	11. MD 207	45
Physician /Medical :aminer	E 70	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	iac or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit the burial - transit	Medical	d. UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 burns after death.  The Funeral Director. After this certificate has been signed by the attending physician and apletely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)  9 Unknown	regnancy	23d. Date of delivery Month	o Day Year
s, P.O. irres that the signed by t	ed by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	1 Yes		pably 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law requir star death.  The Director: After this certificate has been so led in by the funeral director, page 2 should I	Completed		24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of es 2 No
Vital hysician this certi	ro Be	25. Was case referred to medical examiner? 1 Vers 2 No 2 No 2 Control of Death (CF)  Hospital: Impatient 2 Version BR/Outpatient 3 DOA Cother No No No No No No No No No No No No No		sidence 6 Othe	r:
Sion of vertending Ph death.  ctor: After t	ation: T	27. Manner of Death  1 V Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No			
Divisior ospital or Attenc hours after death uneral Director: ly filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	or Town, State	e)	Iral Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
	Ĕ	29b. Signature and title of certifier  29c. License number  O.C.M.E.	OCASE	9d. Date signed <i>(Mo</i> May 7, 2009	nth, Day, Year)
18		30. Name and address of person who completed Guse of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltin	more, MD 21201		
S	tate	31. Date Will Dy, 2009 32. Registrar's gnature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0821 2009 3 Dawson Walter Lord, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Memoria Talbot taston If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/21/1937 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days Min. 1**X** M 2 □ F Yrs 72 MD 209-28-4062 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County an "natural", or items 23a or 28a-f show Medical Experiment the putified at 1 ☐ Yes 2 ☐ No Director MD Caroline Ridgely 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 307 Sunrise Ave. Funeral 21660 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 22∐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XQXNo Specify Specify: <u>ک</u> 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglene Important: If item 27 is marked other the any injury or other traumatic event, the once. Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elwood Lord Elsie Thomas Lord ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Carol Clark/sister 9259 New Lane, Denton, MD 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Greensboro Cemetery 5/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Greensboro, MD 22 Name and Address of Facility
Fleegle and Helfenbein Funeral Home,
106 W. Sunset Ave., Greensboro, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that a used the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 2000060MC **Physician** DAY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 ☐ Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

completely within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

522 lOLEWILD AVE EASTON, MD 2/60/

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day,

29b. Signature and litle of certifier

(Check only

**ORIGINAL** 

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene U

For State Registrar AMENDED #8 PER FH 5/15/09 Certificate of Death CCHD AS 3 Time of Death 2. Date of Death 1. Decement's Name (First, Middle, Last) **Physician** 2009 /Medical 4c. County of Death Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner 264 Rd If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 ☐ F Yrs 221-50-0079 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 17 Is marked other than "natural", or Itama 23a or 28a-f ahow traumatic avent, the Modical Extendible must be morified at 1 ☐ Yes 2 TNO Director MD Queen Anne Maryde1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26477 Barclay Rd. 21649 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Expinibility ODEs. Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2000 White Š Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Arnold Chip Long, Sr. Betty Pinder Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie L. Long/Spouse 26477 Barclay Rd., Marydel, MD 21649 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 Donation 5 Dother (Specify) Templeville Cemetery 5-7-2009 Templeville, MD 22. Name and Address of Facility Flee le and Helfenbein Funeral Home, 106 W. Sunset Ave., Greensboro, MD 2 21. Signature of Funeral Service Licensee 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DC /Medical **Examiner** TERY, OSCIL DISCASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the a 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2 🗆 No certificate 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 XYes 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: within 24 hours after death. To the Funeral Director: After 5 Pending investigation Natural 1 🗀 Yes 2 □ No 2 Accident 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. 0 death (Item 23a) (Type, Print State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Lillian Virginia Lewis 6:00 p. 2009 May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Cambridge Dorchester 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 1 217-09-8673 92 1916 Maryland Nov. Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Dorchester Wingate 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2010 Lewis Road USA 21675 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{X} \text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes Ž□No If Yes, Give Year or Dates: Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) crab picker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Thomas Woodland Julia Ann Meekins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia L. Todd daughter 2010 Lewis Road, Wingate, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 5/8/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature Truneral Serprice Licensee W lemos 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final eilure to 1 mon th disease or condition resulting in death) Due to (or as a consequence of) neumonia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bacteremia Due to (or as a consequence of) IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Examiner as the burial-transi attending physician for use as the buria certificate has been signed by the rector, page 2 should be detached

**Physician** 

/Medical

**Examiner** 

Funeral Director

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Completed

Be

2

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatte event, the New Texture of the traumatte event, the New Texture of the traumatte event, the New Texture of the standard of the New Texture of the Standard of the Standard of the New Texture of the Standard of the New Texture of the Standard of the New Texture of the New Year of The New Year of The New

Department of Himportant: If ite any injury or ot once.

**Physician** 

/Medical

Examiner

altimore, Maryland 21215-0036

Physician/Medical Completed by funeral director, Be Certification: To iours after death. neral Director; Af illed in by the fur

or Attending Physician: The law requires that the death certificate be executed

this

After

To the Hospital o within 24 hours af To the Funeral Di

P.O. Box 68760.

Division of Vital Records,

2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print) Bramble 100

atricia Year)

32. Registrar's Signature

State Registrar

Medical

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registra Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death May 9, 2009 **JAMES** R. MESSENGER 1:40p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House-Montgomery Hospice 8. Date of Birth (Month, Day, Year) March 17,1945 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Min. Days Months 1**X** M 2 □ F 185-34-6924 64 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 No MD Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20876 United States 20300 Watkins Meadow Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 27 No Specify: Specify: White 3 ☐ Widowed 4 🕅 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Consulting Financial Adviser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Deloris Thompson James Earl Messenger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan O'Malley 20300 Watkins Meadow Drive Germantown, MD 20876 (Fiance') 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 2009 Alexandria, VA 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Ligen E.K uctis 10 East Deer Park Dr. Gaithersburg, MD 20877 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Henatic Encephalopathy

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Mones.

event, the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

burial-trag attending physician for use as the buria signed I page this within 24 hours after death

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed 10+1

29b. Signature and title of certifier

31. Date filed (Month)

j. Koudkhou, ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

resulting in death)	a. nepacic Encep									
	Due to (or as a consequence End Stage Liv	,	e							
Sequentially list conditions, it any, cooling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):									
that initiated events resulting in death) Last	C. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown				23d. Date of delivery Month Day Year					
Part II. Other significant conditions	ontributing to death but not resulting	in the underlying ca	use given in Part I.		use contribute to the cause of death?  ☐ No 3 ☐ Probably 4 【 Unknown					
				24a. Was an autopsy performed? 1 ☐ Yes 2 🎇 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No					
25. Was case referred to medical			26. Place of De	ath (Check only one)						
examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DO	Other: 4 🗆 Nursing I	Home 5 Residence	6XOther (Specify) Hospice					
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	. Time of lnjury M	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		farm, street, factory,	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	nysician: To the best of my knowledge miner: On the basis of examination a and manner stated.									

DHMH 17 Rev 1/2001

State Registrar Dr. Jocelyn Toukep Kouatchou M.D. 201 University Pkw. Baltimore, MD

32. Pagistrar's Signature

29c. License number

D0063 74 3

29d. Date signed (Month, Day, Year)

May 9, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Dec. 9, 1955 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 XM 2 F 53 213-66-0052 Dec. Maryland Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show Washington Maryland Boonsboro Director 1 Tyes 2X No injury or other traumatic event, the Medical Examiner must be notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? items 23a or 6106 Clevelandtown Road 21713 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 XNo If Yes, Give Year or Dates Specify: 2 Specify: 3 Widowed 4 X Divorced White Completed 16b. Kind of Business/Industry Refuse Management 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4 or 5+) Elementary/Secondary (0-12) Company Environmental Safety Director is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Arnold Hayes, Jr. Frances J. Monroe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary W. Hayes, Brother permit. Pages 1 and 2 Department of Health an Important: If item 27 is any Injury or other trau 2713 Wild Dogwood Way, Mt. Pleasant, SC 29466 20a. Method of Disposition 20b. Place of Disposition (Name of May 7 ate 20c. Location - City or Town, State cemeter, crematory or other place)
Metropolitan
Crematory 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2009 Alexandria, VA 22. Name and Address of Facility DeVol Funeral Home, Signature of Funeral Serv e Ligensee 10 E. Deer Park Drive, Gaithersburg, MD 20877 1. Exter the disease, or complications that causis the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has Se 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 No Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 1 Tyes 5 Residence 6 Other (Specify) မ Director: After this 27. Mayiner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident Could not be determined 3 🗌 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide e Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (check only 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 2 To the 29b. Signatur title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MO 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAPPOU 600 North Wolfe St, Baltimore, MD, 21287 MMANDUIL 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May 12 Day 2009 **Physician** 9:15 P M Betty McConnell /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Talbot Easton William Hill Manor If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days) Hours Min. Oct. 25, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) . 192<u>3</u> **Funeral** Delaware 218-16-5628 85 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinator ust be notified at Talbot Easton 1 □XYes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 501 Dutchman's Lane 21601 death v Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "1 Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Food Service Originator/ Proprietor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Mills Robert Bradley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Pages 1 and 2 22027 Gannon Drive, Preston, MD 21655 Dufferin McConnell/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition NBurial 2 ☐ Cremation 3 ☐ Removal from State 05/16/09 Federalsburg, MD Hill Crest Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) eond **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical as the attending I 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Vear Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>გ</u> ware 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? walk certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 24 hours after death.

Funeral Director: A filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 / ertifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State Registrar 31. Date filed (Month, Day, Year) MAY 14

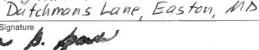
H. Wood,

29b. Signature and title of certifier

William



30. Name and address of person who completed cause of death (Item 2 a) (Type, Print)



29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 1746 Margaret Austin Smith McCraeken 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 191bot HOSPITA aston If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security 7 Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗙 F 218-34-9389 4/30/1936 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 ☐ No Oxford Maryland Talbot 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With items 23a or 101 Bonfield Avenue 21654 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Ye ar or Dates: 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐Yes 2 XNo Specify. 9 Specify: 3 XWidowed 4 ☐ Divorced White "natura!" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pillow Stuffer Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked of George Austin Smith Margaret Salisbury ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If Item 27 I any injury or other tr: once. Margaret Jane Yockey / Daughter PO Box 91, East New Market, MD 21631 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/12/2009 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore Veterans Cemetery 21. Signature of Funeral 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Densis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Winary Iract Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🖟 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 Yo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō e Hospital c 24 hours af e Funeral D 1 🕰 certifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MIN

State Registrar 31. Date filed (Month)

ngragrets.

washington St, Easton, MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $S_0$ ,  $MS_1$ ,  $S_2$ ,  $S_3$ 

			For State Registrar	State of	Marylan	-			ealth a Death	and M	lental Hyg	giene Reg. No.	21111	9	6809
			Decedent's Name (First, Middle, Last	st)							2. Date of Dea	ıth			Fime of Death
	Physici: /Medic		Anna Louise Mil	ls							Month May	8 Day	, Ye 200!	9 4	4:20 P M
3	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death								4c.	County of D	eath		
			Envoy of Denton							0.4 Um	Caroline				
р	Funeral		5. Social Security Number 6. S 213–14–1807	ex □M 2 <b>X</b> □F	7. Age (In yrs. 85	last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	, Year)		Country)	State or Foreign
	Director		Usual Residence of Decedent				L				Nov. 20	0, 1	923 1	Maryla	and
	ryland how		10a. State 10b. County	-	10c. Cit	y, Town or Lo	cation								side City Limits
7	e Ma Ba-f s	Director	MD Carol	ine					Dento	n			1 ☐ Yes 2 No		
ζ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		10e. Street and Number 420 Colonial D	rive			10f. Z	p Code	21629	9		•	Citizen of What Country? USA		
•	ems er mu	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U ces?	.S. 13.	Was Dec	edent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - A Black, V	American Inc Vhite, etc.	dian,
36	safte ,orit	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv	9		1 □ Yes		Specify:				Specify:	whit	:e
Ş	hour Itural	ed b	15. Decedent's Ed	Year or Da	ies.	16a. Dece	dent's Us	ual Occup	ation			16b. Ki	ind of Busine	ess/Industry	
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2	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)								(First, Middle,		Surname)		
Maryland 21215-0036	ould in Mennarke	은	Ansel D. Abbott			1					ine Elze				
Mai	O1 (0 0)		19a. Informant's Name/Relationship ( H. Wayne Bramble		on		-				al Route Numbe n Anne ,		2165		<del>)</del> )
	Health Health tem 27 I		20a. Method of Disposition		20b. I	Place of Dispo	sition (Na	ame of			Date		ocation - City		State
<u></u>	Pages ent of nt: If i		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		itate I	cemetery, cre st New		-		5/1:	2/09	Eas	t New	Marke	et, MD
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licer	•	1				ss of Facilit	•	omas Fui				
m	an me		BIKE	$\supset$		6.7	700 I	ocust	t St.		mbridge				•
Г			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the deat ach line.	th. Do not en	ter the mo	ode of dyin	ig, such as	cardiac o	or respiratory ar	rest,		Inter	roximate val Between
	Physician		Immediate Cause (Final disease or condition	a. Pr	FUN	100	11A							D	et and Death
	/Medical Examiner		resulting in death)	Due to (	or as a consec	quence of):									
Н		-E	Sequentially list conditions, if any, leading to immediate	b. — Due to (	or as a consec	uence of):		-						_	
	uted I Insit	Examiner	Cause (Disease or injury	240 10 (	. 40 4 0011000	, 20,100 01/1									
ď	execting and starting the starting of the star		that initiated events resulting in death) Last	Due to (	or as a consec	quence of):								1	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		_d											
ယ	entifica ing ph e as th	Med	IF FEMALE:									Т			
Box	leath certifica attending ph I for use as ti	Physician/Me	23b. Was decedent pregnant in the past 12 months?		rth 2 Feta	al death 3[		pregnancy	,			1	23d. Date of Month	delivery Day	Year
0	he de the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4⊟Pregna 9□Unkno	ant at time of own	death 5L	Other (	specify)				-		,	
σ.	w requires that the d been signed by the should be detached	/ Ph	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco u	use contribu	te to the cau	use of death?
5	quires n sign ald be	d by	DEMENTIA	, ATH	6200	SCLE	201	16			1 □ Y	es 2	□ No 3	Probably	4 Unknown
Vital Records,	s beel	Completed	CARDIOVAS	CHL	AR T	DISE	AS	E			24a. Was a		24b. Wer	e autopsy fi	ndings available ion of cause of
æ	The lav ite has	omp			3.						autop perfo	rmed? 2 <b>2</b> No	deat	th?	
<u>ra</u>	fan: rtifica	Be C	25. Was case referred to medical examiner?						26. Place	of Deat	h (Check only o		<u></u>	100	
<u>&gt;</u>	hysic his ce I direc	To	1 ☐ Yes 2 No	Hospital: 1 🔲 II	npatient 2	ER/Outpatie	nt 3 🗆 [		4 <b>25</b> JNU	ırsing Ho	me 5 Resid	dence	6 □Other (	Specify)	
n C	Ing P	on:	27. Manner of Death  1 № Natural 5 Pending	,	of Injury h, <i>D</i> a <i>y</i> Yea <i>r)</i>	28b. Time o Injury		28c. Injur Wor			28d. Describe how injury occurred				
Division or	death ctor: /	icati	2 Accident investigation 3 Suicide 6 Could not be		of injury - At h	ome farm st	M reet facto		Yes 2□		28f. Location (S	Street ar	nd Number o	or Rural Rou	ite Number
2	tal or Ars after al Direct	Certification:	4 Homicide determined	buildir	of injury - At h	fy)	Tool, Idok	, omco			City or Tox				no rumboi,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) ↑ Certifying Ph		asis of examina										
	To th withir To th comp	Me	29b. Signature and title of certifier	1/1	/		2	9c. Licens	e number	- 0	( )	29d. Da	ite signed (A	fonth, Day,	Year)
			Jala- Ja	MI	7			000	53	09	4	5	-11-	-20	09
-	5		30. Name and address of person who	completed caus	of death (Iter	m 23a) (Type,		LAIC T	1.416	Δ	1. Fin	1.01	AIC V2	2000	M
	Sta	ite	31. Date filed (Month, Day, Year)	-	sistrar's Sign		1	1	111-6	-17	-7.00	1000	31 20	, 426	
	Registr				V	- 207	132.00	-							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dav **Physician** 5:53 AM Geraldine R. Moore 0,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Lanham Doctors Community Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 🖾 F Months Director 224-36-5274 76 Dec 2, 1932 Philadelphia, PA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a State 10b. County ns 23a or 28a-f show 1 Yes 2 □ No Maryland Prince George's Lanham Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6900 Heidelburg Road 20706 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or item
or other traumatic event, It a Medical Examiner. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗵 No Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary WSSC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John W. Ryan Lida Thinnes ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Moore - Husband 6900 Heidelburg Rd., Lanham, MD 20706 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 5/13/09 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an page 2 s autopsy perform certificate 1 ☐Yes 2 No ors after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 CCCrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

3

State Registrar

completely

DOV filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

DHMH 17 Rev 1/2001

29c. License number

45660

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** 6:45 A.M Jane Richardson Mapes May 9, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince Georgee | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 217 F 579-48-2541 89 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Prince Georges Silver Spring 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country Hygiene. other than "natural", or items 23a or ' rent, the Medical Examiner must be r 3154 Gracefield Road Apt. 401 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🌠 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney Legal 5+ permit. Pages 1 and 2 should be filed very pearment of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the state of the sta 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elliott Richardson Ida Dorothy Strode 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter B. Mapes/Son 5209 Brentford Dr., Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Georgetown University 2009
Medical Center 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Luc 9013 Annapolis Rd., Lanham, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Congestive Heart Failure Due to (or as a consequence of) Examine attending physician and for use as the bunial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? signed by the and d be detached for 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has t irector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) D0055861 May 9, 2009 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B Abdul Munim, M.D. 31. Date filed (Month Day) Year)

State of Maryland / Department of Health and Mental Hygiene ? 1 1 1 - For State Registrar Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 2009 **Physician** 3:25 Thelma McKissick /Medical 4c. County of Death ta. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Capitol Heights Norfield Acres 9. Birthplace (State or Foreign Country)

DC If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 81 Yrs. 8. Date of Birth (Month, Day, )
Aug. 25, 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🗓 F Ĩ927 Aug. 578-42-2638 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Eventuals in ust be notified at 1 X Yes 2 □ No Director Maryland | Prince George's Capitol Heights 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 20743 5501 Norfield Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: Specify: Black 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify: § 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private School Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Joel Trenton Freeman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7017 Kepner Court Lanham, MD 20706 Brenda McKissick/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery May 14, 2009 Brentwood, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service License 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o)heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESTRICTIVE LUNG DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEVERE KYPHOSCOLIOSIS Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed OSTEOPOROSIS burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12,months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 🕱 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After 1 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only ang manner stated the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 11, 2009 MD 19927 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20010 106 Irving St. NW Suite 218 Washington, DC Dr. Navdeep Mathur MD, MPH

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	C.a	Ce	rtificate of	Death	,	Reg. No.	1 10013			
- 30	Physicia	an	1. Decedent's Name (First, Middle, Las	IET N	EWI	MAN	2. Date of De Month	Day Year	3. Time of Death $9:25P$ M				
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	eath	4c. County of Death					
· 10	1.5		Hebrew Home of G			Rocky		Ure Done of Di	Montgo				
	Funeral Director		5. Social Security Number 6. Security Number 1		3. last birthday 35 Yrs.	Months Days		Min. 8. Date of Bir Month, Bar Aug. 2	8, Year 923 N	irthplace (State or Foreign Country) ⊇W York			
-			Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or L	ocation				10d. Inside City Limits			
2	shov	-	Maryland Montgon	_	Rockvi1					1 XYes 2 □ No			
A d	28a-f	ecto	10e. Street and Number			10f. Zip Code			10g. Citizen of What (	Country?			
th with	23a or	al Dir	4613 Cherry Valle	y Drive		208			U. S. A				
G Z I Z I 3-0030 fled within 72 hours offer dooth with the Mandand	perfilt. Tages I and a Should be med within 7 Endors area boost must be marginal parameter of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Movidowed 4 ☐ Divorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Vas Decedent of Hispanic Origin? (Specify Yes or No Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2 No Specify:			nerican Indian, hite, etc. White			
	natur	sted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of	f working	16b. Kind of Busines	ss/Industry			
V :	Mec Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use retire memaker	d)		Own H	ome			
V 2	lygier her th	ខ្ញុ	12 Years  17. Father's Name (First, Middle, Last)		110	memaker	18 Mother's	Name (First, Middle	e, Maiden Surname)				
מוומ	ever	B	Samuel Levengri				l	lotte Com					
	d Mei marke	မ	19a. Informant's Name/Relationship (	· · · · · · · · · · · · · · · · · · ·	19b. Mai	ling Address (Street	and Number o	or Rural Route Numi	ber, City or Town, State	e, Zip Code)			
2 2	th and the strain trains		Stuart Newman - S						ckville, M				
g -	Heal Heal tem 2		20a, Method of Disposition			position (Name of ematory or other pla		Date	20c. Location - City				
Baltimor	ant: If it		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	y)	Mount 1	Lebanon	5	/10/2009		, Maryland			
Dail	Departs Departs Imports any inj once.		21. Signature of Funeral Service Licer	Stattlement	1	1091 Rock	ville P	ike, Rock	ction, Inc	• yland 20852			
1	- 2 -		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused he de	ath. Do not e	nter the mode of dy	ng, such as ca	ardiac or respiratory	arrest,	Approximate Interval Between			
P	hysician		Immediate Cause (Final disease or condition	PNEU	MON	IA				Onset and Death			
	/Medical		resulting in death)	Due to (or as a conse	equence of):	11 = 111	ZMn T	Tinu	1105				
E	xaminer		Sequentially list conditions	b. CONG	ES11	VO MC	09121	41416	UKE				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	as a consequence of):								
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	equence of):								
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08/20	cate physi the l	Medical	•	d									
O. Box	ath certil ttending or use at	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 望 No 9 □ Unknown		23d. Date of delivery Month Day Year								
, J	uires that the de i signed by the a Id be detached f	by Ph	Part II. Other significant conditions	contributing to death but not r	esulting in the	underlying cause g	ven in Part I.		16	e to the cause of death?			
ğ	w require been sig should b	edt	FLIVILL	DUTTOR	<u> </u>	7		_ 1	Yes 2 No 3	Probably 4 Unknown			
Records,	ate has bei	Completed						24a. Wa aut per	formed deat	e autopsy findings available to completion of cause of h? Yes 2000			
			25. Was case referred to medical			<u> </u>	26. Place o	1 Yes of Death (Check only		20110			
<b>&gt;</b>	/sician: s certific lirector,	o Be	examiner? 1 ☐ Yes 2 1 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpat	ent 3 DOA			sidence 6 DOther (5	Specify)			
o i	g Phys er this eral dir	n: To	27. Muniver of Death	28a. Date of Injury (Month, Day Year,	28b. Time				e how injury occurred				
Ö.	ath. or: After i	atio	1 Natural 5 Pending 2 Accident investigatio	n	,,		]Yes 2 □ N						
Division or	l or Afte after dea Directo I in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		t home, farm, ecify)	street, factory, office	9		(Street and Number o own, State)	r Rural Route Number,			
_	To the Hospital or Attending Physician: To the Funeral Director: After this certifica completely filled in by the funeral director, I		(Check only 2 Medical Exa	hysician: To the best of my h	knowledge, de ination and/or	eath occurred at the investigation, in my	time, date and opinion, death	I place, and due to the hoccurred at the time	ne cause(s) and manne le, date and place, and	r as stated. due to the cause(s)			
	the the mplet	Medical	29b. Signature and title of certifier	and mapner stated.		29c. Lice	nse number		29d. Date signed (M	fonth, Day, Year)			
	¥ ¥ C	_	Inau Gree	To her.	1. K	1.0 1	354	36	MAYO	8,2009			
0	2		30. Name and address of person who	completed cause of death (	tem 23a) (Tyr	e Print)	Dage	2000 0 00	MILLE	8, 2009 HD 20852			
			1941 1941 16 16	HUN CIVYA.	D, 61	1 HUND	KUSTK	WHD, RUL	KVIVIO,	M 20896			
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			State Registrar			Ce	rtificat	e of l	Death			Reg. No.	lim W W m		
			1. Decedent's Name (First, Middle	, Last)				-			2. Date of Dea	ath _Day	Year	3. Time of Death	
	Physici /Medio		Toby	N	elson						May	6,	2009	2:26 A.M	
10 mg	Examir		4a. Facility Name (If not institution Shady Grove Ad	_		11		4b. City, Town, or Location of Death Rockville					4c. County of Death Montgomery		
	Funeral Director		5. Social Security Number 096–20–3714	6. Sex 1 □ M 2 ▼ F		s. last birthday) 83 Yrs.	If Unde Months		If Under Hours	Min.	8. Date of Bir (Month, Da )ct. 2,	th 19, Year) 192		thplace (State or Foreign ountry) V York	
	ט		Usual Residence of Decedent											10d. Inside City Limits	
5	e Marylar a-f show	ctor	10a. State 10b. County  Maryland Montg	omery		City, Town or Lo aithers								1 X Yes 2 No	
七	3a or 28	al Dire	10e. Street and Number 152 Kendrick Pl	ace, # 12			1 '	o Code 20878				10g. Citiz	zen of What Co	-	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I health and Mental Hygiene. I have 23a or 28a-f show then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Expriment country.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marr	Armed F ied 1 ☐ Yes If Yes, G	cedent Ever in orces? 2 No	I .	Was Dece If Yes, spe 1 ☐ Yes		lispanic Or an, Mexica Specify:		cify Yes or No Rican, etc.)		14. Race - Am Black, White Specify:		
00	hours ural",	d be	3 Widowed 4 Divorced	Year or	Dates:	16a. Dece	dent'e Hei	ial Occur	ation		-		nd of Business		
21215-0036	vithin 72 sne. shan "nat	Completed	15. Deceden (Specify only highest Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of wo	ork done i ise retired	during mos	st of workin	g		vn Home		
Maryland 2	be filed v ntal Hygie ed other i event, in	Be	17. Father's Name (First, Middle, Isadore Klein	Last)		2.00				er's Name	(First, Middle	Maiden :	Surname)		
Ž	thould nd Me mark matic	ပ	19a. Informant's Name/Relations			19b. Maili	ng Addres	s (Street	and Numb	er or Rura	l Route Numb	er, City or	r Town, State,	Zip Code)	
Z	nd 2 salth ar 27 is r trau		Albert H. Nelso		and		•							Md 20878	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐ Removal from	20b	Place of Dispo cemetery, cre udean M	osition (Na matory or	me of other plac	ce)	D.	ate , 2009	20c. Lo	ney, Ma	Town, State	
Ħ	artmer strant injury		4 ☐ Donation 5 ☐ Other (S		3								n, Inc.		
Ba	permi Depar Impor any Ir		5 Sonald C.	Otott	7									land 20852	
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused he de	eath. Do not en	ter the mo	de of dyir	ng, such as	s cardiac o	r respiratory a	rrest,	-,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	only one cause on	Pneum									Onset and Death  1 Week	
1	/Medical Examiner		resulting in death)	Due to	(or as a cons	equence of): .nson Di		0						5 Years	
		Ē	Sequentially list conditions,	b	Parki o (or as a cons		LSeas					_			
П	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events												
ő,	pertificate be executed ding physician and se as the burial-transit	I Exa	resulting in death) Last	Due to	o (or as a cons	equence of):									
68760,	cate t physic the b	/Medical		d											
O. Box 6	ath o	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live	utcome of preg e birth 2 Fe gnant at time o	etal death 3	☐ Ectopic ☐ Other (s		;y			2	23d. Date of do Month	elivery Day Year	
ds, P.	uires that the de signed by the a d be detached for	ρ	Part II. Other significant condition	ons contributing to	death but not r	esulting in the I	underlying	cause giv	en in Part	I.				to the cause of death? Probably 4 ☐ Unknown	
of Vital Records,	e law requir has been si je 2 should I	Completed									24a. Was		24b. Were a prior to death?	autopsy findings available completion of cause of	
a E	n: Th										1 □ Yes	2 <b>X</b> No		s 2□No	
₹	stcial certi irecto	Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☒ No		Xnastiant 2	☐ ER/Outpatie	nt 2 🗆 🗆	Oth	or:		(Check only		6 ∐Other (Sp	nacify)	
	ding Phystcian: The In. After this certificate ha	5.	27. Manner of Death		e of Injury enth, Day, Year,			28c. Inju Wor			ne 5∟ Hes 28d. Describe			еспу)	
ion	Attending r death. ector: After by the fune	atior	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi		onth, Day, Year,	) Injury	м		k? ]Yes 2.⊑	□No					
Division	al or Atte s after des I Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place	ce of Injury - At ding, etc. (Spe	t home, farm, si ecify)	reet, facto	ry, office		1	28f. Location City or To			Rural Route Number,	
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fi	Medical (	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the Examiner: On the and ma	ne best of my labels basis of exam anner stated.	knowledge, dea ination and/or i	th occurre	d at the ton, in my	ime, date a	and place, eath occurr	and due to the	e cause(s , date and	and manner d place, and di	as stated. ue to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifie	1 //	10		2	9c. Licens	se number					nth, Day, Year)	
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			30. Name and address of person	who'completed ca Schoenbe		16220 F	, Print) 'rede:	rick	Road	, Gai	thersb	urg,	Mary1a	and 20877	
	St	ate	31. Date filed (Month, Day, Year)	2000 32	egistrar's Sig	gnature		_		<del>-</del>					
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DHMH 17 Rev 1/2001

Registrar

MAY 12 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Steven **Physician** 0:25AM 08 09 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Shock Trauma Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 15 M 2 F 220-64-7016 52 7-11-1956 Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar mant be notified at 1 ☐ Yes 2X No WV Berkley Falling Waters Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or: Apt 32 25469 U.S.A. 65 Bodie Dr. Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: white Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) county board of Elementary/Secondary (0-12) College (1-4or 5+) custodial supervisor education 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ray Hansel Orndoff Sr. Betty Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau once. Donna E. Orndoff wife 923 Lanvale St. Hagerstown, Md 21740 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Cem. 20c. Location - City or Town, State May 13, 20a, Method of Disposition y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 2009 21 Signature of Funeral Service Lig Donald Edwin Thompson Funeral Home, P.O.BOX 310 Clear Spring, MD 21722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSUS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease of righty that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examinel Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Morbal Obesity 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy erformed certificate 2 1No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1⊠ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. within 2.

State Registrar

31. Date filed (Month, Day, MAY 12

Knight

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Jenniter

S. Greene 22 32. Registrar's Signature

29c. License number

altimore MD

29d. Date signed (Month, Day, Year)

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 6:00 AM PRATT MAY 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Feb. 4, WOODSIDE GENESIS KEHAB Montgomery 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1934 Virginia 226-38-9973 1 X M 2 ☐ F 75 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Prince George' Laurel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20707 8301 Ashford Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Black If Yes, Give Year or Dates: unknown Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Religion 5+ Pastor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Horace Pratt Pearl Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8301 Ashford Blvd., Laurel, MD 20707 Bessie G. Pratt/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 15, May 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Stafford, Virginia Glen Haven Cemetery 4 Donation 5 Dother (Specify) 2009 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS 2 DAYS Due to (or as a consequence of): 2 weens INCUMONIA Due to (or as a consequence of): UNKNOWN RESPIRATORY FAILURE Due to (or as a consequence of): UNENOWN ACCIDENT CEREBRO VASCULAR 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VEGETATIVE STATE 3 Probably 4 ₩ Known 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No KIDNEY DISCASE 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ NO 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Natural Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

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within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

After th funeral

Physician;

Hospital or Attending

To the within 2 To the I þ

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requires that the death certificate be executed

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**Physician** 

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**Funeral** 

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7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Expositer must be refilled at

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than '

item 27 i

Department of Important: If it any Injury or o

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?

> PERSISTENT CHRONIC

HYPERTENSION

5 Pending

examiner? 1 Yes 2 No

28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 □Yes 2 □ No

investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License number DOOG 3978 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MIN

32.

Registrar's Signature

CENTER DRIVE, HINA SYGD, M.D, GREENWAY 7525 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death , Day 2009 ear **Physician** 6, 9:07 P M May BERNADINE PINDELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gaithersburg Montgomery 6 Bradenton Court Months Days Hours Min. Feb. 24, 1945 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 1 F 64 219-44-7568 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Mortaal Examination at the notified as gones. MD Montgomery Gaithersburg 1 XYes 2 □ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 Bradenton Ct 20878 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mission Sucess Manager Lockheed Martin 4yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis M. Pindell Ethel M. Griffin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louis M. Pindell-Brother 732 Gatestone St Gaithersburg, MD 20878 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 5/13/09 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) d 22. Name and Address of Facility Snowden Funeral Home, PA 21. Signature of Funeral Service lice 246 N. Washington St Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CANCER Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 No 1 ☐ Yes 2 🛛 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37236 May 8, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn B. Hendricks, MD 6410 Rockledge Dr #506 Bethesda, MD 20817 32. registrar's Signature 31. Date filed (Month, Day, State Registrar

		4	For State	State of	f Marylan				Ith and M		giene Reg. No.	009	16819		
700			Registrar Commodite of Beauty							Date of Death     3. Time of Death					
	Physicia									Month May	Day 11	2009	1:50 P M		
	/Medic Examin	-	Andrew Charles Palguta  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death							1107	4c. County of Death				
	Examin	C.	7756 Shore Drive					eston			(	Caroli	ne		
	Funeral		5. Social Security Number 6. Se	x M 2□F	7. Age (In yrs.		If Under Months		Under 24 Hrs. ours Min.	8. Date of Bird (Month, Da	y, Year)	Cou	place (State or Foreign intry)		
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	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits		
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	r 28a r notif	Directo	10e. Street and Number				10f. Zip	Code			10g. Citizen	of What Cou	untry?		
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	r dea	Funeral	11. Marital Status	Armed Fo		.S. 13.	Was Deced	lent of Hispar cify Cuban, M	nic Origin? (Spe Mexican, Puerto	ecify Yes or No Rican, etc.)	14.	Race - Amer Black, White			
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p	tal Hy d othe	8	17. Father's Name (First, Middle, Last)					18.	Mother's Name	(First, Middle	, Maiden Su	rname)			
yla	2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", ar items 23a or 28a-f show raumatic event, the Medical Examiner must be notifiled at	은	John Palguta			405 14-5	Un o Andrian		Susan Number or Rura	al Pauta Numb	or City or T	own State 7	in Code)		
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Tanana Mary M. Palguta/	wife			Ů	s Lane		Easton					
e,	s 1 and 2 of Health a item 27 is other trau		20a. Method of Disposition	WILE	20b. I	Place of Disp cemetery, cr				Date		tion - City or			
nor	ages ant of t; If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify						n 05/12	2/09	Chest	ter. Ma	aryland		
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature of Funeral Service Licen					<u> </u>	f Facility Helfenbe				_ <del>-</del>		
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ā	Physician		Immediate Cause (Final disease or condition	a	Acut	re le	ukm	10					2 WKS		
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):									
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	the dea y the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□Unkn	nant at time of lown	death 5	☐ Other (s)	рес <i>пу)</i>							
P.0	that the de led by the s detached t		Part II. Other significant conditions of	ontributing to d	leath but not re	sulting in the	underlying o	ause given ir	n Part I.	23e. Did	tobacco use	contribute to	the cause of death?		
Records,	88 15 8	d by								1	Yes 2	No 3□Pi	robably 4 ∐Unknown		
COL	> 0 10	lete								24a. Wa	s an	24b. Were at	utopsy findings available		
Re	9 - e	Completed			-					per	opsy formed? 2 No	death? 1 ☐ Yes	completion of cause of 2 □ No		
Vital	ician; Th certificate ector, pag	Φ	25. Was case referred to medical					26	6. Place of Deat		one)				
_r <	Physician; this certificral director,	To B	examiner? 1 ☐ Yes 2D No	Hospital: 1 🗆	Inpatient 2				4 ☐ Nursing Ho				ecify)		
n or			27. Manner of Death  1 Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time Injury	/	28c. Injury at Work?		28d. Describe	how injury	occurred			
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b		e of injury - At h	l form	M		s 2□No	28f Location	(Street and	Number or B	ural Route Number,		
Division	lor Atlanta	Certification:	4 ☐ Homicide determined	build	ding, etc. (Spec	ify)	otreet, lactor	y, omoc			own, State)				
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Pl	miner On the	e best of my kn basis of examir nner stated.	nowledge, de nation and/or	ath occurred investigation	at the time, n, in my opin	date and place lion, death occu	, and due to th rred at the time	e cause(s) a e, date and p	nd manner a blace, and du	s stated. e to the cause(s)		
	To the Within 2 To the comple	Mec	29b. Signature and title of certifier	1/1			29	c. License nu	umber		29d. Date	signed (Mon	th, Day, Year)		
			<b>\</b>	//				0666	370		5	12.	09		
			30. Name and address of person who	completed cau	ise of death (Ite	em 23a) (Typ	e, Print)	0	nve"	201 6			m-1 200 =1		
			31. Date filed (Month, Day, Year)	150n	Registrar's Sign	Sd3	1120		nve =	501 C	asit	m /	10 21601		
	St Regist	ate trar	MAY 14	2009	Registrar's Sign	B. 1	gare	and the second							
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-										

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 2009 JonAnthony 11:41 A. M Ramon Proctor 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death mon 3030 Ocemanto in rckering 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours Min. 1 € M 2 🗆 F 30 220-15-6210 5, Germany Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 XYes 2 No Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13030 Pickering Drive 20885 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 21 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Autoclave Technician Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) M. Teresa Smith Claudie Wavern Proctor Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudie W. Proctor Jr./ Father 20876 20036 Gatestead Circle, Germantown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hopehill Cemetery 5/11/2009 Fredrick, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not either the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to ( \* as \* consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □ No. 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

and

attending physician

After this certificate has

4 hours after death. death.

within 24 hours a

filled in by the

be executed

Box 68760.

P.O.

Division of Vital Records,

Physician:

Department of Health an important; If item 27 is m any injury or other

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

à

Completed

Be

?7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Expriner must be notified at

2 should be filed within 72 hours after death with 1 n and Mental Hygiene. Is marked other than "natural", or Items 23a or 2

Baltimore, Maryland 21215-0036

Examine as the burial-transi

Physician/Medical ò signed by the a Completed by been si should page 2 Be Certification: To funeral

IF FEMALE:

1XYes 2 □ No 27. Manner of Death

5 Pending investigation 6 Could not be

determined

28a. Date of Injury (Month, Day, Year) May 5 2009 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28h Time of UnE

Home

1 ☐ Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

Dr. Germantown, mo

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

and manner stated. Signature and title of certifier rmp omE

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ira Brecher 2101 Medical Park Dr. Suite#304 Silver Spring, MD 20902 31. Date filed (Month, Day,

State Registrar 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death 3:19 P.M **Physician** May 7, Edward Daniel Palik 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Clinton Tospital Center Southern Maryland 8. Date of Birth (Month, Day, Year) Sept. 21,1928 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min Months 1 □XM 2 □ F 298-26-9726 80 Ohio Sept. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modest Examinar must be refined at 1XYes 2 No MD Fort Washington Director Prince Georges 10g. Citizen of What Country? 10e Street and Number should be filed within 72 hours after death with Ind Mental Hygiene.
marked other than "natural", or items 23a or I 20744 United States 904 Pocahontas Drive Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify: 2 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Research Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be t 2 should be file the and Mental H Christina Dinga John Palik ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is in any Injury or other traur Susan Y. Palik/ Wife 904 Pocahontas Drive, Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place)

Georgetown University May 7,2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 □ Other (Specify) Medical Center 22. Name and Address of Facility Columbia Mortuary Services, P.A. of Funeral Service Licenses 9013 Annapolis Road, Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oneumnia Physician /Medical Due (or as a consequence of) Examiner Disease ARKINSMI Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician at the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) detached for 9 Unknown signed by 1 I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown icate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Hospital or Attending Physician: The 44 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No certificate 1 □Yes 2 □ 25. Was case referred to medica examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Waturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely f (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi 300 11701 Livingston Road, Fort a Askington, Mas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \) \( \) \( \) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year Day **Physician** 5 2:20 p. M Clifford Elwood Rogers May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Marys Charlotte Hall Veterans Home Charlotte Hall 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct. 11, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Year) 1921 **Funeral** Hours Days Months 1 □XM 2 □ F Delaware 87 214-32-0680 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Charlotte Hall 1 ☐ Yes 2 ☐ No St. Marvs **Funeral Director** 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number USA 20622 29449 Charlotte Hall Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ∐Yes 2 XXNo Specify: white <u>م</u> WWII 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) sawmill operator 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Armenia King Hobart Rogers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 is any injury or other trau 5962 Ridge Spring Circle, Salisbury, MD Fave Adams daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/8/09 Maryland Veterans Cem Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ye of Funeral Service Licenses Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** OLON CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner THRIVE AILURE 10 Sequentially list conditions, if a.y., bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ULCER DE CUBITUS Due to (or as a consequence of): HTN Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated.

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. certificate has been signed by the rector, page 2 should be detached this certific al director, After after death | Director; d in by the f within 24 hours aft

To the Funeral Di

completely filled in

physician and s the burial-trans

attending pl for use as t

death with the Maryland 28a-f shov

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

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23a

items

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"natural"

por

DHMH 17 Rev 1/2001

State Registrar

FRANCISCA BRUNEY 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie





30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

MD 20622

109

CHARLOTTE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death May 5 2009 **Physician** Rizvi Gouhar 4:35 рм /Medical 4a. Facility Name (If not institution, give street and number)
Univ. of Maryland Medical Ctr 4b. City, Town, or Location of Death
Baltimore 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Country) **Funeral** Days Hours Months 1 ☐ M 2 💢 F 136-08-9223 Pakistan Director 18 1956 Usual Residence of Decedent 10c. City, Town or Location or 28a-f show be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Silversprin Director Montgomer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? them 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 20910 Spring St. USA death v Funeral Race - American Indian Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own home Home maker 12 Department of Health and Mental Hy, Important: If Item 27 Is marked other any injury or other trainment. 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) AHMED 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 19a. Informant's Name/Relationship (Type. Print) Spring St. Son 1001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Laurel maryland 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/06/2009 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespondence of the death. So not enter the mode of dying, such as cardiac or respiratory arrespondence of the death. Approximate Interval Between Onset and Death Months Immediate Cause (Final disease or condition resulting in death) End Stage Liver Disease **Physician** /Medical Due to (or as a consequence of): Examiner Hepatitis C 6 yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ XIo 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1□ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ Xo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Mopatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

P.O. Box 68760 Division or Vital Records,

To the Hospital or Attending Ph within 24 hours after death.

> To the Funeral Director; After th completely filled in by the funeral f)

B

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2009

29b. Signature and title of certifier

and manner stated.

29c. License number

D66267

of person who completed cause of death (Item 23a) (Type, Print) tabatabai, 22 S. Greene Street, Baltimore, Md 21201

29d. Date signed (Month, Day, Year) May 7, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Edward SMITH, JR. 2009 Harry 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 8,1925 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Months Days Hours Min. 1 ☑ M 2 □ F 83 Maryland 220-16-3031 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🛣 No Keedysville Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21756 5606 Mt. Briar Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 No 1943-1 ☐ Never Married 2 🕱 Married Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced 1946 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cement company maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlotte Elizabeth Harper Harry Edward Smith, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5606 Mt. Briar Road, Keedysville, Maryland Lola V. Smith - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 12,2009 Mav Hagerstown, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorial 4 Donation 5 Dother (Specify) Minnich Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 415 East Wilson Blvd., Hagerstown, Maryland 21740 Vestal Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final to Celulihis and assess Sepris du disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions cause. Enter Underlying Due to (or as a consequence of): livery Day Year the cause of death? 4 4 Unknown robably

**Physician** /Medical Examiner

attending physician and for use as the burial-trar

permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Weddon Exam out to be pulling and

Hygiene.

12 should be filed with and Mental Hygier 7 is marked other the

72 hours after death with

Baltimore, Maryland 21215-0036

Examine Be Completed by Physician/Medical as signed by the a page 2 should funeral director, Certification: To nours after death. neral Director: Af illed in by the fur

Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of):									
IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy  1	23d. Date of delivery  Month Day Year								
Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?								
ischem'c Card	dompopally, chronic Klidney	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Union wn								
disease, Peul	sheral da cular diseas.	24a. Was an autopsy performed?  1 □Yes 2 □Ne 24b. Were autopsy findings available prior to completion of cause of death?  1 □Yes 2 □No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 ☐ H	ospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5 Residence 6 Other (Specify)								
27. Manner eath	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28c. Work?	8d. Describe how injury occurred								

within 24 hours a

To the Funeral C completely SH- 6+1

Hospital or Attending Physician: The law requires that the death certificate be executed

this certificate

Division of Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

and manner stated

29c. License number D62588

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Hagestow, my

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 Pending investigation

6 □Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TVD INT MBAOUA A D 251 E. Anhietam St. JUD ITH MBAOUA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

1 atural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

31. Date filed (Month, Day, Year) distrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death g<sup>Day</sup> Month **Physician** 2009 17:18 M Nancy Lou Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/12/1940 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F PA 69 187-32-6975 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Evaninar must be notified at 1 ☐ Yes 2 No Director PA Lebanon Lebanon 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ----- any injury or other traumatic events. USA 17046 10 Dead End Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2 □XNo Specify. Specify: white 2 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer Turner Violet Kreiser ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Dead End Road, Lebanon, PA 17046 Candace L. Smith / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/13/2009 Harrisburg, PA Cremation Society PA 4 ☐ Donation 5 ☐ Qther (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Fervice Licensee 108 William St., Berlin, MD 21811 23a. Part 1. Shife' the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MMED IATE MYOURDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): 20c 9 Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. であり//1///シャップvのグ/ Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 ☐Yes 2 ☐ No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 SNOW ST. SNOW HILL, MB. 21863 BA 4 ZWOZTH, /// 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Regist**A**:MENDED #6 PER FH 5/15/09 Certificate of Death CCHD AS 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 2009 St. Aubin May Marguerite Ellen 6 1:20P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline 25393 Depue Landing Way Greensboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr. 2, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Year Hours Ohio 289-30-9988 1933 Director 76 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Caroline Greensboro Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a United States of America 25393 Depue Landing Way 21639 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Completed by 3 Widowed 4 Divorced Caucasian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Ellen Elizabeth Waldick Floyd. Eugene Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Terrie Stonbraker Daughter 368 Conniston Way, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 5/7/2009 Dover, Delaware 21. Signature of Funeral Service Lice 22. Name and Address of Facility Moore Funeral Home, P.A. Denton, Maryland 21629 Second 23a. Part1. Enter the diseas se, or complications that caused the death. Do not e List only one cause on each list. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 415 mos. Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9☐ Unknown 9 ☐ Unknown cate has been signed by page 2 should be detact 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1□ Yes 2□No 1 ☐ Yes 2 ☐ No Division or Vital To the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 3□ DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funeral (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide to the cause (s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar title of certifler

29b. Signature and

DHMH 17 Rev 1/2001

eleted cause of death (Item 23a) (Type, Print)

De

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mont /5/2009 Year Todd Haigler Scroggs

3. Time of Death

9:05am

(State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 🔂 No

DC

Day

1 - For State Registrar Physician /Medical Examiner **Funeral Director** show Director Funeral ≥

> and burial-trar attending physician for use as the buria ate has been signed by the page 2 should be detached within 24 hours after death.
>
> To the Funeral Director: After this certificate I completely filled in by the funeral director, pagr

4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton Prince George If Under 1 Year If Under 24 Hrs. Birthplace Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours Min 1**⊠** M 2□ F Yrs. 67 3/10/1942 225-52-2972 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified at once. MD Charles La Plata 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8870 Robert Morgan Pl. 20646 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. White Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Computer Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Haigler Scroggs Florence Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tammy Pierce Daughter 8870 Robert Morgan Place La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Atlantic Crematory 5/9/2009 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mecmonia v. M **Physician** Ker I wahren /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physiclan; The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☑ No 1 □Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and middle. I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 yd title of certifier 29d. Date signed (Month, Day, Year) 29b. Signatu 29c. License number DOUS5120 mi) nd address of person who completed cause of death (Item 23a) (Type, Print) 1329 Southern avenue SE Soute 310 Workington WHARD ALMERMO

State Registrar 32. Registrar's Signature

			Pleas	e Type or Prin				. Ensure A Health and N		_	ible.	
		For State Registrar		State of Mi	ai yiai iu		tificate of			Reg. No. 2 (	009	16828
Physicia		1. Decedent's Name			SOLOMO	ON JR			2. Date of Dea Month MAY 4	th Day 2009	Year	3. Time of Death 3:22 A M
/Medic Examin Funeral		4a. Facility Name (I.	- 6 cg	give street and number)  Sex  1 M 2 F	e (In yrs. la		4b. City, Town, o	r Location of Death	8. Date of Birth (Month, Day SEPT 20	4c. County	9. Birthp	place (State or Foreign
Director		578-80-6 Usual Residence of		149 M 2L F	45	Yrs.			SEPT 20	1963		INGTON, DC
Marylan -f show  -	tor	10a. State	10b. County PRINCE	GEORGE'S		Town or Lo	marlan				1	0d. Inside City Limits ‡☐ Yes 2 ☐ No
with the	Funeral Director	10e. Street and Nur 74 OLD EN	mber				10f. Zip Code 2077	4		10g. Citizen of USA		ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. It. Acades Examination that the motified at once.	ρ	11. Marital Status	ied 2□ Marrie	12. Was Decedent Armed Forces?	Ever in U.S. No	- 1	Nas Decedent of H fYes, specify Cub	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		ce - Americack, White, e	etc.
within 72 horene. than "natur	Completed	(Special Special Speci		Education grade completed) College (1-4or 5	5+)	(Give life, L	dent's Usual Occup kind of work done DO NOT use retire DSCAPE	during most of world	king	16b. Kind of E		dustry
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d 2 should I th and Men 7 is marke traumatic	은	19a. Informant's Na	ame/Relationship			19b. Mailir 6700	ng Address (Street	FRANC and Number or Ru LAKE PLA	ral Route Numbe	er, City or Towr	n, State, Zip	, <sub>Code)</sub> 20743 MARYLAND
iges 1 and of the self item 2 or other		20a. Method of Disp	position Cremation 3	□ Removal from State	cei	ace of Dispo metery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or To	own, State
permit. Pa Departmer Important: any injury once.		4 ☐ Donation  21. Signature of Fu	5 □Other (Spe une)al Service Li		RIV		E CREMAT	ess of Facility J.			-	
Physician		shock, or hea immediate Cause	art failure. List or (Final	omplications that caused have one cause on each li	ne.	Do not ent	er the mode of dyi	OVER ROAD ng, such as cardiac VASCULA	or respiratory ar	rest,		20785 Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	on	Due to (or as	a conseque	ence of):	CH147	VASCULA	2 14 20	7 0/3		
executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
eath certificate be executed attending physician and for use as the burial-transit	<u></u>			d	,							
The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the burn	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									ate of deliv	ery Day Year
w requires that the despension of the signed by the should be detached		Part II. Other signit	ficant condition	s contributing to death b	out not result	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did to		ntribute to ti 3	he cause of death?
n: The law re ificate has bee or, page 2 sho	e Completed by	25. Was case refer	grad to madical						1 □ Yes	rmed?	were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
hysicia this cert	00	examinor? 1 ☐ Tes 2 ☐	] No				II 3 LI DOA		ome 5 Resid	dence 6 □O		fy)
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 s	Certification: To	27. Manner of Deat  1  Natural  2  Accident  3  Suicide  4  Homicide	th 5 ☐ Pending investiga 6 ☐ Could no determin	t be 28e. Place of Inj	ay, Year)		Wo	ryat rk? ]Yes 2 □ No	28d. Describe h	Street and Nun		al Route Number,
spital or nours afte neral Dir / filled in		29a. Certifier		Physician: To the best	of my know	vledge, deat			e, and due to the	cause(s) and r		
o the Ho vithin 24 h o the Fu	Medical	(Check only one)  29b. Signature and		xaminer: On the basis of and manner st		ion and/or in	vestigation, in my 29c. Licen:			date and place 29d. Date sign		
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		Salvado	or Sil	ho completed cause of o	0/ 14	OSPI	tal D	rive	Cher	erly,	MAY	lad
Sta Registr	_	31. Date filed (Mon	LUUJ (	32. Registi	rar's Signati	re				V/		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and rtificate of Death		ene 009 16829						
			Registrar  1. Decedent's Name (First, Middle, Last)	Timodio or Bodin	2. Date of Death	3. Time of Death						
	Physici		Andrea L. Springer		Month April 2	9. 2009 1515 M						
- Age	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death						
-	LXumm		Prince George's Hospital Center	Cheverly		Prince George's						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs Months Days Hours Min.								
	Director		215-23-8699 1□M 2덫F 25 Yrs.	World's Buys Trouts William	06/30/19	983 DC						
	pur w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le		10d. Inside City Limits							
	faryla sho	5			11 <b>∑</b> IYes 2 ∐ No							
	28a-i	Director	MD   Prince George's   Clinton	100	. Citizen of What Country?							
	with 3a or			10f. Zip Code 20735								
	ns 20	era	6004 Edward Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Specify Yes or No- to Rican, etc.)	USA 14. Race - American Indian,							
36	be filed within 72 hours after death with the Maryland ital Hygiene.  ed other than "natural", or items 23a or 28a-f show event, if we Mudical Exactive must be neoffied at	Completed by Funeral	Armed Forces?  1 ★Never Married 2 ★ Married   1 ★Yes 2 ★No If Yes, Give Year or Dates:	to Rican, etc.)	Black, White, etc.  Specify: Black							
21215-0036	2 hou	pe	15 Decedent's Education 16a, Dece	dent's Usual Occupation	16	6b. Kind of Business/Industry						
212	a. B. Martie	ple	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)									
21	d with giene	ĕ	12 4 Regi	P	rofessional Testing							
g	e filed al Hygi I other event, I	Be (	17. Father's Name (First, Middle, Last)	me (First, Middle, Ma	aiden Surname)							
<u>Xa</u>	should be filed within and Mental Hygiene. s marked other than umatic event, the manatic event eve	2	Emerson Springer	urant								
<u>a</u>	2 is			ng Address (Street and Number or R								
e,	1 and Health em 27 ther ti					Clinton, MD 20735						
Baltimore, Maryland	iii O L		1 Ma Buriai 2 □ Cremation 3 □ Hemoval from State	osition (Name of matory or other place)		•						
			4 □ Donation 5 □ Other (Specify) Resurrec  21. Signature of Funeral Service Ligenses 2	18/2009	Clinton, MD Funeral Services							
g	permit. Departr Importa any Inju			500 Allentown Rd.								
			23a. Part . Enter the disease, or complications that caused the death. Do not en									
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Brin 9	n 1	Onset and Death						
	/Medical		resulting in death)  a. Due to (or as a consequence of):	010,00								
	Examiner	L	Sequentially list conditions. b. Motor VC	hicle C	rash	6						
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	. 1	Leton d	) ME						
	xecut and al-tran	xan	that initiated events resulting in death) Last Due to (or as a consequence of):	10 AN B	100559	21						
8/60	ficate be executed physician and s the burial-transit	dical E		AN X	Hoos							
8	tificat g phy as the	edic	U	7								
ROX	death certifi e attending p d for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery						
_•	ed for	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year						
7. D	at the d by th etache	Phy	9 U Onknown	and discount of the Politic	00c Did tabo	age use contribute to the course of death?						
က်	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?  2 ☑ No 3 ☐ Probably 4 ☐ Unknown						
0	requi	eted				<del></del>						
Hecord	0 - 0	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?						
	iician: The l certificate h rector, page					No 1 ☐ Yes 2 ☐ No						
VIta	ding Physician: th. After this certifics funeral director, p	œ										
0	Phy:	<u>1</u>	1  Yes 2  No	nt 3 LI DOA 4 LI Nursing I	Home 5 ☐ Residen 28d. Describe how	ce 6 Other (Specify)						
sion	th. th. the fune	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Car Accident										
<u>s</u>	Attender death	ifice	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)			eet and Number or Rural Route Number,						
5	s after all Dir	Cert	Rt.5 North of Woo	dyard Road	City or Town,	Clinton, MD						
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical (	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place	e, and due to the car curred at the time, dat	use(s) and manner as stated.						
	To the vithin To the somple	Me	29b. Signature and title of certifier	29c License number	296	d. Date signed (Month, Day, Year)						
	6		Camp ( CA)	- N4038/	0 1	146 2 2009						
	21		30. Name and address of person who completed cause of death (Item 23a) (Type, DR. CARVELL COPER 3001 HOSP)		RLY MS	30707						
F	Sta	te		IN- M- OTILYE	5, 1 10.	= 0 10 (						
	Registra		31. Date filed (Month, Day, Year)  AN 122003 Security Signature  A 2 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item I per dr., g891,05/26/09dhb 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Donald Schuerholz Year **Physician** 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner 21784 Carrol MO airhave VKesulle If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 86 216-16-1155 1 **X**M 2 ☐ F MD 8/28/1922 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental hygiene.

• marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 □Yes 2K□No Sykesville Carroll Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 7200 3rd Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 BYes 2□ No 1942— If Yes, Give Year or Dates: 1946 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Consulting Engineer 4 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other 17. Father's Name (First, Middle, Last) Be Mary Anarino William A. Schuerholz 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7200 3rd. Ave., Sykesville, MD 21784 Louise E. Schuerholz Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other 3 Removal from State 5/6/2009 Marriottsville, MD Crest Lawn Mem. Gdns. 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature of Fundral Jer M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TSTOLIC D15 60 repor Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No for 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9∏Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed? Yes 2 las 2 NO 1 Yes certificate l 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 20 1 Inpatient Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 140) Thomas Vento, 114 Business Center Drive, Reisterstown, MD 21136

Registrar

State

31. Date filed (Month, Day, Year) NAY 05 2009

parke

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		•	For State Registrar	ate of Mary		rtificate of l			g. No.	09	168	31
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month May 08,	Day	Year	3. Time of 0	
	/Medic	al	Conrad L. Trahern  4a. Facility Name (If not institution, give stree	t and number)		4b. City. Town, or	Location of Death	may 00,		ty of Death		
	Examin	er	Casey House			Rockv			Mont	gomei	cy	
	Funeral Director		5. Social Security Number 442–20–5500 6. Sex		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/13/1	Year) 925	Cou	place (State or intry) ahoma	r Foreign
	DQ 3 0		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	cation					10d. Inside Cit	y Limits
	f sho	5	Florida Volusia		Ormond	Beach				i	1 □Yes	2 🔀 No
	28a-	Director	10e. Street and Number	10	10g. Citizen of What Country?							
3	3a ol	al D	l John Anderson Dri	ve Apt.#8	05	3217	76		Unite	d Sta	ates	
	items ?	Funeral	11. Marital Status	Vas Decedent Ever Armed Forces? □Xes 2 □ No	in U.S. 13.		ispanic Origin? (Sp un, Mexican, Puerto	ecify Yes or No- Rican, etc.)	BI	ack, White		
0000	hours after death with the Maryland tural", or items 23a or 28a-f show al Evon iner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	f Yes, Give Year or Dates: WW	II	1 □ Yes 2X No	Specify:		Specify:		erican	India
C 7	ined within 72 il Hygiene.  other than "natrent, il Modelle"	(Specify only highest grade completed) (Give kind of work done during most of working								Gove	ernment	
7	Hygiel Hygiel Int, In		17. Father's Name (First, Middle, Last)	5+	Cons	urtant	18. Mother's Nam	e (First, Middle, N			ETHMENC	
5	d be t antal l red of	Be C	Roy Trahern				Cassy	Juanita	Presto	n		
JE Y	should be and Mental s marked o	2	19a. Informant's Name/Relationship (Type. I	Print)	19b. Mailir	ng Address (Street	and Number or Ru				ip Code)	
Š	alth a alth a alth a 27 is		Conrad Trahern Jr.	(Son)	1930	2 Sherwoo	od Green					79
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		sition (Name of matory or other place tan Crema	1143	11	20c. Location		rown, State , Virgi	nia
Dalti	Departm Departm mportar any injur		21. Signature of Funeral Service Licen	7/10	22	2. Name and Addre	ss of Facility De eer Drive	Vol Fune	ral Ho	me		
			23. Part 1. Ent ir the disease, or complication shock, or leart failure. List only one car	ons the caused the						, 110	Approximate Interval Bet	e
	hysician		In a distance of the Control							-	Onset and I	Death
	/Medical		discrete of condition resulting in death)	Congestiv		rallure						
E	Examiner		Sequentially list conditions.									
-	p tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events c	Due to (or as a co	nsequence of):							
Ž,	tricate be executed g physician and as the burial-transit	I Examiner	that initiated events c resulting in death) Last	Due to (or as a co	nsequence of):							
68/60,	icate b physic the b	edical	d									
	ath cert attendin for use	Physician/Me	in the past 12 months?	If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	y .			Date of del Month		Year
S, P.O.	ires that the de signed by the a		Part II. Other significant conditions contrib	uting to death but no	ot resulting in the u	nderlying cause giv	en in Part I.				the cause of c	
ğ	w require s been sign should b	ted	Endocarditis					1 🗆 Y	es 2∐No	) 3∐Pi	robably 4X	Unknown
Kec	sician: The law r certificate has by irector, page 2 sh	Completed by	-					24a. Was a autops perform	sy	prior to death?	utopsy findings completion of c : 2 □ No	available ause of
II.	clan: ertific ector,	Be	25. Was case referred to medical examiner?			I ou		th (Check only or			**	•
5	Physical this call direct	ျ	1 Yes 2 No Hosp	1 L Inpatient	2 ER/Outpatie	III 3 LI DOA		ome 5 Resid			city) Hosp	ice_
on O	ding in the state of the state	tion:	27. Manner of Death  1X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Ye		Wo	k?  Yes 2□No	280. Describe II	ow anjury occ	unou		
Endocarditis    Continued and property of the following o								28f. Location (S City or Tow	treet and Nu n, State)	mber or R	ural Route Nun	nber,
_	Hospita 24 hours Funeral stely filled	Medical C	29a. Certifier 1 Check only one) 1 Medical Examiner	an: To the best of m : On the basis of exand manner stated	amination and/or i	th occurred at the to	ime, date and place opinion, death occu	e, and due to the curred at the time, c	cause(s) and date and plac	manner a	s stated. e to the cause(s	s)
	o the	Mec	· · · · · · · · · · · · · · · · · · ·		<del></del>	29c. Licen	se number		29d. Date sig	ned (Mont	th, Day, Year)	
			29b. Signature and title of certifier  Tocelyne ICE	uatch	ou, mi	) DOC	63748	7	May	09, 2	009	
	14+1		30. Name and address of person who comp	leted cause of death	(Item 23a) (Type,	Print)					2.1.1.2.1	
			Jocelyne Kouatchou			lty Parkw	ay Baltin	nore, MD.				
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	had s						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Marylan  1 - Registrar		artment o				giene Reg. N2	09	16832
Dhua	latan	Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Vear	3. Time of Death
Phys /Me	dical	Everett Tribbitt		_			May		.009	3:40A™
Exam	niner	4a. Facility Name (If not institution, give street and number)			wn, or Location	n of Death		4c. County	of Death oline	
Funer	al	Caroline Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	Dent	ear If Unde	er 24 Hrs.	8. Date of Birt	th I		lace (State or Foreign
Directo		216-03-9370 1XM 2□F	93 Yrs.	Months D	ays Hours	Min.	10/21/	1915	Coun	MD MD
and w		Usual Residence of Decedent   10a. State   10b. County   10c. C	ity, Town or Lo	ocation					1	0d. Inside City Limits
Maryl: -f sho ied at	to		idgely							1 X Yes 2 □ No
h the or 28a o notif	Director	10e. Street and Number	rugery	10f. Zip Co	ode			10g. Citizen of V	What Coun	itry?
ath wif		210 Park Ave.			1660			USA		
er dez Items	Funeral	11. Marital Status  12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Deceden If Yes, specify	t of Hispanic C Cuban, Mexic	Origin? (Spe can, Puerto	cify Yes or No- Rican, etc.)	- 14. Rad Blad	ce - Americ ck, White,	
ING 21215-0036  be filed within 72 hours after death with the Maryland tall Hygiene.  dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	P S	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💆	No Specif	fy:		Specify	y: Whi	lte
5-0036 72 hours af natural", or dical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual C	occupation	ast of warkii	na I	16b. Kind of B	usiness/Inc	dustry
nithin han "	alg m	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work of DO NOT use i	etired)	oot or working	'9	Food Dw		idaa
filed v Hygie int, th	ပိ	17. Father's Name (First, Middle, Last)	Supe	rvisor	18. Mot	ther's Name	(First. Middle.	Food Pr		e Tild
<b>—</b> 0 = 0 = 0	To Be	Acie Tribbitt			1		dith Hu		,	
Tary 2 shou and N is mai		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (S	treet and Num	ber or Rura	l Route Numbe	er, City or Town,	State, Zip	Code)
and:		James Tribbitt/Son					ville,			
Baltimore, Maryland 21 permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important; if then 27 is marked other than yilly or other traumatic event, the		14 Bullat 2   Clettlation 3   helitovatifull State		osition (Name of matory or other			ate	20c. Location -	•	
nit. Parantime ortani	انه	4 □Donation 5 □ Other (Specify) Gr  21. Signature of Funeral Service Licensee		ro Ceme				Greensb		
and and and and and and and and and and	ouo	Menh C Eleet						neral H sboro,		P.A. 21639
7		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.								Approximate Interval Between
Physicia		Immediate Cause (Final disease or condition resulting in death)	DMC	Wia						Onset and Death
/Medica Examine	_	Due to (or as a conse	quence of):							
	Je la	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury  Cause (Disease or injury	quence of):							
ecuted ind transit	Examiner	triat initiated events								
ecords, P.O. Box 68/60, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		Due to (or as a consect	quence of):							
687 ificate g physias the	edical	d								
BOX 68 feath certifica attending ph	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet		⊒Ectopic pregr				23d. Da	ate of delive	ery
C. E. Ithe deal of the deal for	sicia	in the past 12 months?  1  Yes 2  No 9  Unknown  1  Yes 2  No 9  Unknown		Other (speci				Mo	onth	Day Year
Hat the de ed by the a		Part II. Other significant conditions contributing to death but not re-	sulting in the u	inderivina caus	e given in Par	t I.	23e. Did to	obacco use cont	tribute to th	ne cause of death?
Hecords, Phe law requires that has been signed begge 2 should be deta	d by	Deneutia			3		1 🗆 '		,	ably 4 ∐Unknown
aw rec	Completed	Coronary Ante	nv	Dist	2G5		24a. Was	an 24b.	Were auto	psy findings available
The ate h	Som	Dichettes Mal	Mito	25				rmed?	death?	mpletion of cause of 2□ No
Or VITAI Physician: T this certificat ral director, pa	Be (	25. Was case referred to medical examiner?  Hospital: Hospital:				ce of Death	(Check only o	пе)		
P & p	-T	1  Yes 2  Inpatient 2	ER/Outpatier 28b. Time o					dence 6 Oth		y)
VISION C Attending F r death. ector: After by the funera	tion	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	м 230.	Injury at Work? 1 ☐ Yes 2 [		od. Edderibe i	iow injury occur	red	
DIVISION I or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At houilding, etc. (Special Countries)	ı ıome, farm, stı <i>ifv)</i>	reet, factory, o	ffice	2	28f. Location (S City or Tov	Street and Numb	per or Rura	al Route Number,
oltal or urs after eral Direction to										
DIVISION  To the Hospital or Attend within 24 hours after death  To the Funeral Director; completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my kn (Check only one) 2 ☐ Medical Examiner: On the basis of examiner and manner stated.	owledge, deat ation and/or in	h occurred at to restigation, in	the time, date my opinion, d	and place, a leath occurr	and due to the ed at the time,	cause(s) and made, date and place,	anner as st and due to	tated. o the cause(s)
To the within 2 To the complex	Me	29b. Signature and title of certifier		29c. Li	cense number	r		29d. Date signe	d (Month,	Day, Year)
)		I fames sixes.	MI	D	3/2	20		5-82	209	
		30. Name and address of person who completed cause of death (Ite	m 23a) (Type,	Print)	1-1-	2 K	-	x 48	2 0	11 20
	State	31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature A	ente	U ST	بر ال		x 1/8	- 7	624
Regi		31. Date filed (Month, Day, Year) 32. Registrar's Sign	B.	parts						

KN

09-03856 Beverly A. Tolson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 16833

			1- For State Certificate of Death								Reg. No.						
Phys		n/ 1	1. Decedent's Name (First, Middle,Last)								Date of De Month May 14,	Day	Year		Time of Death 1751 hrs	n .	
			a. Facility Name (if not institution Prince Georges Coun	on, give street and n		4	b. City, Tow Cheverl		cation of I	Death			c. County of E				
					Ta A . Oa lass	A bintbalass)	If Under 1	-	If Under 2	24Hrs	8 Date of F	Birth (MN	/DD/YYYYY 9	. Birthpl	ace (State or	Foreign	
Funer Direct		5	215-52-5074	6. Sex	7. Age (In yrs. las	61 Yrs.	Months	Days	Hours	Min.			1948	Count	ry) i <b>ry1an</b> d		
		1	Jsual Residence of Decedent				1										
any		1	0a. State 10b. County		10c. City, T	own or Location	on								d. Inside City		
i i i		- h	Maryland Princ	ce George	¹s	S	eat P	1eas	ant						X Yes 2	No	
re Maryland or 28a-f show	8t 0r		10e. Street and Number				10f. Zip Co	ode				_	log. Citizen of What Country?				
the M	Liffed	11. Manital Status 12. Was Decedent Ever in U.S. Armed Forces? 1									United States						
with	oe no									cify Yes or I	Yes or No- 14. Race - American Indian, Black, white, etc.						
death rr iter	nust									,							
after	iner	ğ.		vorced If Yes, Give Y or Dates:		16a. Deceden	Yes 2 X			ad af u	ork done	116h	Specify: E				
hours	Exam		15. Decedent's Education (Spe		rade completed) (1-4 or 5+)	during me	ost of working	ng life. E	O NOT u	se retire	ed)	100	Tang or Doon	1000/1110	Jen. y		
36 in 72	lical	Completed	Elementary/Secondary (0-12	College		Executi	ve As	sis	tant	Sec	retar	у	Pri	vate	9		
with Swith	Ne	탉	17. Father's Name (First, Middle										n Surname)				
21215-0036 suld be filed within 7 Mental Hygiene.	nt, th	Be	James Harpe								Ford						
212 ould b	ic eve		19a. Informant's Name/Relation										City or Town,				
MD 12 sho th and	nmat	Ĺ	Jewel Harper	/ Daughte	er		Cole			Or.			Location - C		20748		
Te, land	er fra		20a. Method of Disposition  1 X Burial 2 Crematic	on 3 Removal	Cr	lace of Dispos rematory or otl	ner place)				Date	- 1					
Pages	i d		4 Donation 5 Other S	Specify:	, Ft.	Lincol	ln Cen	nete	ry_M	lay	23, 20	JOB			d, Md.	•	
Baltimore, MD oermit. Pages 1 and 2 sho Department of Health and	in be	ľ	1. Signature of Funeral Pervice	L bsee	1-	22. N	lame and A	ddress (	of Facility	D.C.	ewart	run	eral H hingto	ome, n. T	C 200	)19	
	_		23a. Part I. Enter the dise se, of	MUNICH					_						Approximate	_	
Physic			failure. List only one caus	o on each line											Between On Deat		
ami		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular disease or condition resulting in death)  Death  Death															
				b.				_									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		s a consequence of	):											
		Examiner	(Disease or injury that initiated events resulting in death) Last	Due to /or o	s a consequence of	):								$\neg$			
uted	- transit		events resulting in death) Last	d				- 00	<del>, , , , , , , , , , , , , , , , , , , </del>	10 IV	o min						
5	ial - t	sician/Medical	X UNPENDED	AMENDE	<sub>D</sub> 23a,PI.	1,2/,pe	erME,	g89	1 5/4	29/0	9 11						
<b>8760,</b> ifficate be	g physician a	ğ	IF FEMALE:	45-	es, outcome of pregr			. [					23d. Date of	delivery Da	21/	Year	
<b>687</b> ertific	iding e as t	ian/	23b. Was decedent pregnant in past 12 months?	1	e birth egnant at time of dea	2 Fe		3	Ectopic	: pregna	incy		Month	D	ay i	Cai	
Box 68	e attending p for use as th	Sic	1 Yes 2 No 9 🗸 U	leknoum -	known	2 _ 0	ther (Speci	y)									
tthe o	detached f		Part II. Other significant cond	ditions contribution	g to death but not re	esulting in the	underlying	cause g	iven in Pa	rt I.	11				ne cause of d		
P.O	signed to	d by	Terminal r	enal dise	ease							Yes 2			ably 4 🗸 U		
rds, requir	peen :	Completed									a	vas an utopsy	p	rior to co	opsy findings empletion of c	available ause of	
e law	has 2 s	Ę			*							erforme es 2		eath?	3 2	No	
8	tificat or, pa		25. Was case referred to media	cal			2	6.Place	of Death	(Check	only one)						
/ita	his certificate director, page	o Be	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier	t 3 D	DA	Other <sub>4</sub>	Nursir	ng Home 5		sidence 6	Other:			
of 9	28d. Describe how injury occurred																
On tendir		atio		ending					'es 2								
Division of Vital Records, Hospital or Attending Physician: The law requing thours after death.	eral Direct filled in by	Certification:	3 Suicide 6 Co	ould not be 28e. F	Place of Injury - At he	ome, farm, str	eet, factory,	office b	uilding, et	tc.		on (Stre vn, State		er or Rui	ral Route Nun	nber, City	
Spital 100urs 2	filled	Cer	4 Homicide	etermined (Spec			_						\d	an atata	nd.		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.	To the Funeral Director: completely filled in by the		29a. Certifier (Check only one) Certifying	Physician: To the xaminer:On the ba	best of my knowled	ge, death occi ind/or investig	urred at the ation, in my	time, da opinion	ite and pla , death oc	ace, and courred	at the time,	cause(s date and	) and manner I place, and d	ue to the	e cause(s)		
To the within	To t	Medical	29b. Signature and title of cert	and mann	er stated.				e number					_	nth, Day, Year,	)	
		15	QuoP)					O.C.I				N	May 15, 20	009			
	,		30. Name and address of pers	son who completed	cause of death (Item	1 23a)											
CR	1			ssistant Medic		111 Penn	Street, E	Baltimo	ore, MD	2120	1						
VI"	e	toto	OA Data filed (At all Day Ver	ar) 32	Registrar's Signat	yre Mad											
		tate															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** DICKIE TAWES 2315 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur Salisbury Rehabilitation & Nursina Ctr. Wicomico Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 21, 1933 **Funeral** Months Days Hours Min. 1 TYM 2 TE 220-26-8208 75 Maryland Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar must be notified at 1 X Yes 2 □ No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 U.S.A. 135 N. Park Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DX'es 2 No 953 If Yes, Give Year or Dates: 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NASA Project Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Tawes Katherine Evans ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other tra once. 135 N. Park Drive - Salisbury, MD Joan Tawes (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation Sunnyridge Memorial Park 5/12/09 Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature Friend Service Licentary Robert H. Bradshaw, 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, . Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Var. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. the detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 icate has been si 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate | 2 🗆 No 1 □Yes 2 1 NO Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 **N**O Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

William H. Robins

200

M.D

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** Mary Ann Watkins 2009 12:24 A May 6. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1438 Knightsbridge Turn Anne Arundel Crofton If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
May 21,1942 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🕅 F 120-32-9663 66 May Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Crofton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1438 Knightsbridge Turn 21114 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years Office Manager Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Troy M. Watkins Virginia Rose Chadderdon ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn G. McDowell/ Partner 1438 Knightsbridge Turn, Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Mother (Specify)Entombment Lakemont Cemetery 4 Donation 5/9/09 Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lears **Physician** Ongestive /Medical Due to (or as a consequence of): Examiner Pulmonary Hy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed COPD burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy وَ Month Year Day 5 Other (specify) ned by the a detached f ☐Yes 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed after death.

Director: After this certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ filled in by the funeral 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number death (Item 23a) (Type, Print) 31 Date filed (Month State Registrar

For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05-23-2009 **Physician** 1845 Ordelle C. Bell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Bel Air Harford upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Min. Months Days Hours 1 □ M 2 🗓 F 213-20-7499 06-25-1917 Director 91 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Ne dical Evantian must be notified at 1 ☐ Yes 2 ☐ No Director MD Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1603 Martha Ct #304 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes Give 3 ₩ Widowed 4 □ Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Clark Ida Davis ည 05/23/2009 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 Martha Ct #304 Deborah C. Hill (Daughter) Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05-26-2009 Bayview Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ea resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trans MOCO14434 Due to (or as a consequence of) O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the detached 9 Unknown signed by t the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò 20 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Division of Vital 1 □Yes or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cent D60768

State Registrar 5,00

pper chesapeake Dr, Bel Air, MD

ss of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Bryant 01:00 Mae Pearl 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore <u>Union Memorial</u> Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Year) Days 1 □ M 2 □ F 73 Director 216-32-9798 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show ed other than "natural", or items 23a or 28a-f show event, it e Medical Examinar must be notified at 1 ☐XYes 2 ☐ No Baltimore Director NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21216 2704 Roslyn Ave Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Safeway Courtesy Clerk 8th grade na marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important; If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Lula Smith Joseph Currin Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2704 Roslyn Ave, Baltimore, Md 21216 Terrell Prettyman-Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/29/09 Timonium, Dulaney Valley 22. Name and Address of Facility of Funeral Service Licer 21. Signatu March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final 5 days Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 🗆 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 □ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0

State Registrar

DHMH 17 Rev 1/2001

Union Memorial

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G891, 5/27/09 WS
State of Maryland, Department of Health and Mental Hygiene
mend 20b, perFh g894

8/21/09 TT

Reg. No.2 0 0 9 Amend 20b, perFh g894 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year Physician 6:59PM REDWN 2000 RONALD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE VA MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 08 03 9. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Days Months Hours 3.72.606 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ns 23a or 28a-f shov must be notified at 1 Yes 2 No MD Baltimore Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Avenue Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant I filem 27 is marked other than "natural", or Items 23. 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 X Yes 2 ☐ If Yes, Give Year or Dates: Never Married 2 Married 2 □ No 1 ☐ Yes 2 XNo Black Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 Is marked other than "natul other traumatic event, the Medical 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Baltimore ( rectional 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (Birst, Middle, Last) Be stin Brown Pauline Solomon 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1307 N. Woodington Ballo. MD 21229 Road Date UN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/28/2009 104/09 Vaughn Owings Mills, MD 1 ■Burial 2 □ Cremation 3 □ Removal from State ō Department of Important: If any injury or Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) C. Green Fundral SICO 21. Signative of Funeral Service Licensee Randall Stown MD21133 cardiac or respiratory arrest disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart Immediate Cause (Final disease or condition PONTANEOUS BACTERIAL RELITONITIS Physician resulting in death) /Medical Due to (or as a consequence of) Examiner YEARS RRHOSI Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9∏Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 1 ☐ Yes 210 No 1∐ Yes 2 - No the Hospital or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient after death.
I Director: After this of in by the funeral dire 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 200C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOUE TAMES m.D 10 N. GREEN STREET, BALTIMORE, MI) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 27 2009 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Norma Stafford Briscoe 4a. Facility Name (If ngt.institution, give street and number) 4c. County of Death Town, or Location of Death Baltimore Himore HOS 01 101 If Under 1 Year If Under 24 Hrs. 8. Days of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Year) Days Hours 1 □ M 2 🔽 76 220-28-2018 1933 16 ЙD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 XYes 2 □ No NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 3209 YOSEMITE AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 X No Specify Specify: 3 ₩ Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paraprofessional 12th 2yrs. Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANNA LEE OTTO STAFFORD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type. Print) 3450 Carriage Hill Circle Randallstown, MD Joyce Briscoe Neale - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

**Physician** /Medical Examiner

**Physician** 

/Medical

10a. State

MD

Examiner

**Funeral** 

Director

d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

Item 27 Is marked other traumatic

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

Baltimore.

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Saowin

Funeral Director

Be Completed by

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and filled in by the funeral dir

Division of Vital Records, P.O. Box 68760

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	21. Signature of Funeral Service Lice	nsee				4300 1	Wabash Ave.
	Jugue	> 13- Kete	March Funera	J. Home We	st, Inc.	Balti	more, MD #15
	23a. Part . Enter the dispase, or come shock, or heart falkere. List only Immediate Cause (Final disease or condition resulting in death)	. HEMATEME	SIC	uch as c <i>a</i> rdi <i>a</i> c or res	spiratory arrest,		Approximate Interval Between Onset and Death HOUNS
Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Soploge Consequence of Due to (or as a consequence of Due t	al Cancer				Years
nysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	livery Day Year
ed by PI	Part II. Other significant conditions		e to the cause of death?				
Complete					24a. Was an autopsy performed? 1 □Yes 2 No	prior to death?	utopsy findings available completion of cause of
3e (	25. Was case referred to medical examiner?			. Place of Death (Ch	neck only one)		
	1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Ou	utpatient 3 DOA Other:	4 ☐ Nursing Home	5 ☐ Residence	6 ☐Other (Spe	ecify)
Medical Certification: To	27. Manner of Death  1 Natural 5 Pending investigation	(Month, Day, Year)	Time of njury at Work?  M 1 □ Yes	28d. 2 □No	Describe how injur	ry occurred	
Certific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		rm, street, factory, office	28f. I	Location (Street ar City or Town, State	nd Number or R	ural Route Number,
edical (	29a. Certifier (Check only one) 1 Certifying Ph	hysician: To the best of my knowledge miner: On the basis of examination an and manner stated.	e, death occurred at the time, on ad/or investigation, in my opinion	date and place, and on, death occurred a	due to the cause(s t the time, date and	and manner a d place, and due	s stated, e to the cause(s)
Ž	29b. Signature and title of certifier  H. Marwo-	_, MO	29c. License nu	~ ~	29d. Da	te signed (Mont	th, Day, Year) 2,009
	30. Name and address of person who  HELE A HAR U  31. Date filed (Month, Day, Year)	completed cause of death (Item 23a)	yai Hospite	alof.	Baltlu	ove	
A	31. Date filed (Month, Day, Year)	32. Registrar's Signature	to a Mad	Λ			

Registrar

State

09-04105	
John Henry Ballman	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 1684	2	0	0	9		6	8	L
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		1- For State Registrar	Certi	ficate of L	Death		Re	g. No.		
Physicia	n/	1 1 Decodent's Name (First Middle Last) 2. Date of Death								3. Time of Death
Medical Examin		John Henry Ballman					Month May 23, 20		еаг	0900 hrs
		4a. Facility Name (if not institution, give stree Franklin Square Hospital Cente	•	ŀ	City, Town, or Lo Rosedale	ocation of Death		4c. County Baltimo	y of Death ore Coun	ty
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24Hrs	8. Date of Birt	h(MM/DD/YYY	(Y) 9. Birthr	place (State or
Director		220 08 6821 1XM 2	F 37	Yrs.	Months Days	Hours Min.	Aug.23	, 1971	Court	Maryland
any	- }	Usual Residence of Decedent  10a. State 10b. County	10c. City. To	own or Location	)					10d. Inside City Limits
<i>b</i> ≥		Maryland Baltimore		iddle R						1 Yes 2 X No
he Maryland or 28a-f show fied at once.	륈	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Vhat Countr	ry?
with the Maryland ns 23a or 28a-f sho	Director	3707 Red Grove Rd.			212	220		Ţ	USA	
with ms 23	era		Vas Decedent Ever in U.S. Armed Forces?		Decedent of Hispa , specify Cuban, I				ce - America	an Indian, Black,
5-0036 let within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medital Examiner must be notified at once.	Funeral	1X	Yes 2 No		_		rtiodii, cto.)	1	.White	_
s after		3 Widowed 4 X Divorced If Yes, or Date	es:		es 2 X No Usual Occupatio		work done	Specify 16b. Kind of E		
hour "natu	ted	15. Decedent's Education (Specify only high Elementary/Secondary (0-12) C	ollege (1-4 or 5+)	during mos	t of working life. I	OO NOT use reti	red)	TOD. KING OF L	Jusinessiin	uusii y
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed by	12	silogo (1 You or)	Co	ntractor	2		Cons	struct	tion
5-0C led with	8	17. Father's Name (First, Middle, Last)	(First, Middle, M	Maiden Surnan	ne)					
	Be	John H. Ballman Jr.	Vass							
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event,	٩	19a. Informant's Name/Relationship (Type, P			Address (Street					
e, MD I and 2 sho Health and item 27 is		Pamela Pikla (Mothe			ed Grove		Date	20c. Location		
Baltimore, A permit. Pages I and Department of Health Important: If item		1 X Burial 2 Cremation 3 Re	moval from State cre	ematory or other	r place)	·			·	
t. Pag		4 Donation 5 Other Specify: 2 Signature of Funeral Service Licensee	Hol1		Mem. Gard		8/2009	Baltin	nore,	Maryland
Baltimore permit. Pages I Department of F Important: If Injury or other	ļ		12 60	Bru	zdzinski	Funera	lHome P	.A.		
Physician	$\dashv$	John W. Burkeu	ns that caused the death. I	o not enter the	mode of dying, s	uch as cardiac o	or respiratory arr	est, shock, or h	neart	Approximate Interval
/Medical		failure. List only one cause on each line	diac arrhyth							Between Onset and Death
xaminer			(or as a consequence of):					-		
		Sequentially list conditions,	(or as a consequence of):						_	
	nin	if any, leading to immediate Due to cause. Enter Underlying Cause (Disease or injury that initiated	(or as a consequence or).							
nd atted	Examiner	events resulting in death) Last  Due to	(or as a consequence of):							
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760, ficate be g physici the buri	Med		c. If yes, outcome of pregna	incy			-	23d. Date	of delivery	
687 ertifica ding p	an/I		Live birth	2 Feta	I death 3	Ectopic pregn	ancy	Month	. D:	ay Year
30x 68 feath certifi e attending for use as	sician	1 Yes 2 No 9 Unknown g	Pregnant at time of deat Unknown	n 5 Othe	er (Specify)					
D. B the d by the	Phy	Part II. Other significant conditions contr		ulting in the un	derlying cause gi	ven in Part I.	23e. Did to	obacco use co	ntribute to t	he cause of death?
, P.O. res that the signed by be detach	d b						1 Ye	s 2 No	3 Proba	ably 4 🗸 Unknown
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tal Rec		25. Was case referred to medical	,		26.Place	of Death (Check		2	1 0	
Vita ysicia his ce direct	To Be	examiner?  1 ✓ Yes 2 No	al: 1 Inpatient 2 🗸 E	R/Outpatient	3 DOA	Other: Nursi	ng Home 5	Residence 6	6 Other:	:
1 of Jing Ph		27. Manner of Death	8a. Date of Injury (Month, Day, Year)	28b. Time of Inj	.	at Work?	28d. Describe	how injury occ	urred	
ion trendi leath. tor: /	atio	1X Natural 5 Pending 2 Accident Investigation		E	1 Y	es 2 No			1.5	
ivis or At after d Direc	Certification:	3 Suicide 6 Could not be	8e. Place of Injury - At hon	ne, farm, street	, factory, office bu	ilding, etc.	28f. Location ( or Town, \$		mber or Rur	ral Route Number, City
Divi	Cer	7 nonlicide	(Specify)							
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the	the best of my knowledge ne basis of examination and	e, death occurre d/or investigation	ed at the time, dat on, in my opinion,	te and place, and death occurred	d due to the cau: at the time, date	se(s) and man and place, an	ner as state d due to the	ed. e cause(s)
	Me	29b. Signature and title of certifier	nanner stated.		29c. License	number		29d. Date si	igned (Mor	nth, Day, Year)
		by his nos			O.C.N	И.E.		May 24,	2009	
		30. Name and address of person who comple Ling Li, MD Assistant Medic			, Baltimore, N	MD 21201				
ν .	ate				.,		<del></del>			
Regist		31. Date filed (Month, Bay Year)	32. Registrary Signature				1 800 64			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of M	arylan		artment of F	lealth and N Death		giene Reg. No. 2	2009	1684
			1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Edward Preston	Burton Sr.					May	21	2009	7:45 P M
	Examin		4a. Facility Name (If not institution,	give street and number)			*	r Location of Death	_		ounty of Death	
1			BERLIN NURSING				BERL:	IN If Under 24 Hrs.	Lo Data of Bio		WORCEST	
	Funeral Director		5. Social Security Number  218-01-9539  Usual Residence of Decedent	S. Sex 7. Ag	ge (In yrs. I 89	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Jan • 4	1920 1921	0 Mar	place <i>(State or Foreigi</i> ntry) Y <b>land</b>
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Econtinal must be rudffind at once.	Funeral Director	Maryland Word	ester	Ве	erlin	10f. Zip Code			10g. Citize	en of What Cou	1 □Yes 2X No
	3a ol	al D	204 West Stree	et			21811			US	A	
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	)- 14	Race - Ameri Black, White,	
ဖွ	after or ite	亞	1 ☐ Never Married 2 ☐ Marrie		No		1 □Yes 2 ဩNo	Specify:	o i noan, etc.)	1	'nnoifu	
003	ural",	d by	3 Widowed 4 □ Divorced	Year or Dates:							wn	ite
P.	72 h "natu	ete	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done	during most of worl	king	16b. Kind	of Business/Ir	idustry
ا 12 ك	within sne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retire			Pofr.	igorati	on Company
ar d 2	Hygid Hygid ther	ပ္	17. Father's Name (First, Middle, L	l ast)		_ Owne:	r /Operat	18. Mother's Nam	ne (First, Middle			on company
n, Edward P. Maryland 21215-0036	d be ental ked o c eve	To Be	John Collings					Bessie	Ruth S	tocks	dale	
N Y	shoul nd M marl	F	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Zi	p Code)
ton,	nd 2 salth a 27 ls		Edith Scott / I			P.O.	Box 272	, Berlin,	Maryla	nd, 2	1811	
.t.	es 1 and 2 of Health fitem 27 I r other tra		20a. Method of Disposition	- 0	20b. P	lace of Dispo	sition (Name of natory or other place	ce)	Date	20c. Loca	ation - City or T	own, State
Bur timor	Pages nent of int: If it iry or o		1 ☑Burlal 2 ☐ Cremation : 4 ☐ Dorlation 5 ☐ Cher (Sp	B □ Remoyal from State ecify)			utheran (		7/2009	Jo	ppa, Ma	ıryland
SR. Burto Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service L		#/	22	2. Name and Addre		cComas d, Abin			
			23a. Partil. Enter the disease, or o shock, or heart failure. List of	omplications that cause	d the death							Approximate Interval Between
de	Physician		Immediate Cause (Final disease or condition resulting in death)	a. CONO	LEST	v£	HEAR	T F	ALLUR	E		Onset and Death
	/Medical Examiner			Due to (or as	a consequ	uence of):						
	tuted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or se	a consect	Janna orj						
,092	ate be executed hysician and the burial-transit	ical Exa	resulting in death) Last	Due to (or as	a consequ	uence of):						
687	ficate g physis the			0.	_							
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeurs after death.  To the Funeurs after death.  Completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3[	☐ Ectopic pregnand ☐ Other (specify) _	cy		23	3d. Date of deli Month	very Day Year
σ.	that the		Part II. Other significant condition	ns contributing to death t	out not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
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Divisi	I or Atten after deat Director: d in by the	Certification: To	2 Accident Investigation 3 Suicide 6 Could not determine	at ha	jury - At ho tc. <i>(Specif</i>	ome, farm, sti y)	reet, factory, office			(Street and wn, State)	Number or Ru	ral Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		Physician: To the best examiner: On the basis and manner s	of examina							
	To th within To th comp	Me	29b. Signature applitte of certifier				29c. Licen:	se number		29d. Date	signed (Month	ı, Day, Year)
			> Managed and and and and and and and and and an	Mus/	donth /li-	MI		515		5/2	2/09	
_	2+1		30. Name and address of person v			n 23a) (Type, <b>//</b> /	B Z	ATT-1	n 11/2	KE I	W SH	TIBLAYA

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:55 2009 CHRISTINA KATHARINA BLEVINS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Timonium Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 □ M 2 🔀 F 19, 1940 Germany Director 215-60-4486 68 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Expraince must be netitived at 1 ☐ Yes 2√2 No Director Maryland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21040 205 McCann St. Germany Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Black, White, etc. - American Indian 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: þ White 3 Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Plastic Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Katharina (nmn) Best Otto (nmn) Simon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1112 Willow La., Farmersville, TX 75442 James A. Blevins / Son 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air, Maryland Bel Air Memorial Gdn: 5-27-09 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kuss 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final Physician METASTATIC ADENOCARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner burial-transi Due to (or as a consequence of): the attending physician the dor use as the burial of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown ficate has been sig r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗆 No 1 ☐Yes 2X No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 ☐ Yes 2 K No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE Certification: To this 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death.
 Funeral Director; After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one X Nurse Practitioner or stated. 29a. Certifier Medical completely To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

2009

CHRISTINA BLEVINS

DHMH 17 Rev 1/2001

JACKIE JONES, CRNP

Enve S. Jak

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 25. Year **Physician** 2009 9:15 Рм **Bluso** J. George /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Hospice 9. Birthplace (State or Foreign Country)
Ohio If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov. 18, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**X** M 2□ F Nov. 88 295-03-9272 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City. Town or Location 10a State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, II = [Vedical Examination nutsing the rediffect at 1 ☐ Yes 2 No Funeral Director Timonium Baltimore  $Md_{-}$ 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 USA 2525 Pot Spring Road K101 12. Was Decedent Ever in U.S. Armed Forces? 1XX (es 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 □ Never Married 2 □ Married 1 □Yes 2**X**□No Specify: Completed by White 3 ₩ Widowed 4 □ Divorced WWII Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic man." Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning Business Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucia Longo Samue1 Bluso ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21224 2515 Boston St. Unit P1 Kathy Thanner/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation SXXOther (Specify) Entomb Dulaney Valley Mem. Grd. 5/30/09 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) tending physician a r use as the burialpe Physician/Medical the aftending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached in 1 TYPS 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐Yes 2 ☐ No Physician: director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After this Certification: To funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred al **or Att**eration are after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one Nurse Practition Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760.

GEORGE BLUSO

Baltimore, Maryland 21215-0036

2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Year Day **Physician** 22, Sarah Lois Besaw Mav 2009 2:08pm /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) July 16, 1945 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funera! 1 □ M 2 □XF Months Days Hours Min 214-44-2793 63 NC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, Ite Medical Event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 X No Directo MD Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 1801 Dunwoody Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tailor Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edmond Locklear Sarah Belle 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Jonathan F. Besaw (Spouse) 1801 Dunwoody Road Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 5/27/2009 Sykesville, MD 21. Signature of Funeral Service License FUNERAL HOME & CHAPEL Brian M00764 PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** vancreatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2√2 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed Yes 2 After this certificate 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 105 proce Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Æ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST 32. Registrar's \$ State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #19a, perFh g891 5/27/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 2000 Day 23 Physician 9:30 AM **BROWN** DOROTHY /Medical 4a. Facility Name (If not institution, give street and number) b. City, Town, or Location of Death BALTIMORE 4c. County of Death Examiner N/A UNION MEMORIAL HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | NO(Yout), Dry 127 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days GERMANY 216-18-6565 1 □ M 2/CXF 94 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 271s marked other than "natural", or items 222 and 11 marked other than "natural", or items 222 and 222 and 11 marked other than "natural". 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21210 USA 16 OLMSTED GREEN Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: þ Specify: WHITE 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) CHILDREN'S RETAIL SELF EMPLOYED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DREIFUSS META **FREHSE** 0TT0 2 19a. Informant's Name/Relationship (Type. Print)
GERRY
SCHOENEMANN/SON
Gary 19b. Mailing Address (Street and Cumber of Bural Boute Number City of Tayon, State, Zip Code) 21117 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition CHEVRA AHAVAS CHESED 5/24/2009 1 M Burial 2 Cremation 3 Removal from State RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FactSOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 nauce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 hours Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner 2 days INFECTION CLOSTRIBIUM MIFFILILE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. iis certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 MALNUTRITION 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD AT.2438946 MAY 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) i0 OLARU M.D. ANDREEA UNION MEMORIAL HOSPITAL, BAUTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Seven D. park

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05-22-2009 Kathleen M. Castro 0837 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harve de Grace Harford Memorial Hospital Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 09 -25 -19 44 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 64 MD 212-44-1247 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Cecil Perryville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 311 St. Mark's Church Rd 21903 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 [X] No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fiscal Clerk State Hwy Admin. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph S. Chaney Mildred E. Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mark J. Castro (Son) 320 Foreland Garth Abingdon, MD 21009 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05-28-2009 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licersee NO Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Multiorgan disease or condition resulting in death) Due to (or as a consequence of): Septic Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Septic arthritis resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Drodenum 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 4No 1 ☐ Yes 2 ☐ No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 hpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner requires that the death certificate be executed and I-trar nding physician ise as the burial Division of Vital Records, P.O. Box 68760, ase atten for us been signed by the should be detached page 2 s has this

**Physician** 

/Medical

MD

Director

Funeral

Completed by

Be

ပ

Examiner

Physician/Medical

þ

Completed

Medical Certification: To

4 ☐ Homicide

29a. Certifier

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Mental Control of the control

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After To the Funeral Director: completely filled in by the

> State Registrar

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and tittle of certifier 63420

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAURE de GRACE, MO. 21078 501 S. UNION 31. Date filed (Month, Day, 32. Registrar

09-04018 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Andrew Cooper, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day May 20, 2009 1110 hrs **Medical Examiner** 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number **Baltimore County** Catonsville 31 Lincoln Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Country) Months Davs Hours Director 2 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 XNo : 23a or 28a-f show notified at once, permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10e. Street and Numbe 2. Was Decedent Ever in U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married Yes Black 1 Yes 2 No specify: Specify: Widowed Divorced If Yes, Give Yaar ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) 18 Mether's Name (First, Middle, Maiden Surname) Be ٩ Name/Relationship ( 19b. Mailing Address (Street and Number or Rural Route Number, City or 20b. Place of Disposition (Name of cen etery, Disposition crematory or other place) Cremation 5 Other Specify Donation Signature of Funeral Service Licenses k Y Year the disease, or complications that caused the death. Do not enter the mode of dying, such as Approximate Interval Between Onset and cardiac or respiratory arrest, shock, or hea **Physician** only one cause on each line /Medical Death Heroin intoxication and cocaine use Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Physician/Medical 23a,27,28a-f,perME, g891 5/27/09 TT X UNPENDED AMENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Day 3 Ectopic pregnancy Year Live birth Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò ۵ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate ✓ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: 26.Place of Death (Check only one) funeral director, 25. Was case referred to medical Division of Vital Be examiner? Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene After this ٥ 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: Yes 2 X No Natural unk Pending within 24 hours after death.

To the Funeral Director: the 1 Fd 5/20/09 FD 11:00 am Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 31 Lincoln Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be Single family residence determined Catonsville, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registra

Medical

To the

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Carol Allan, MD

29b. Signature and title of certifier

111 Penn Street, Baltimore, MD 21201

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 21, 2009

and manner stated

ORIGINAL

09-04141 Keon Cameron

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 24, 2009 1445 hrs Medical Examiner Keon Cameror 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Social Security Number **Funeral** Min Months Days Hours Director 1X M 2 F 217-29-7748 7-31-1990 MD 18 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 X Yes 2 No 28a-f show MD l other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. N/A Baltimore permut. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21218 U S Street Α 1801 Ε. 28th Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Black Widowed Give Year Specify Divorced Yes 2 X No specify. ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School 12th grade N/A Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jessica Brown Terrell Cameron traumatic event, Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Tanya Whitson-Grandmother Street BALTO, 1801 28th MD20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Zion Cemetery 1 X Burial 2 Cremation 3 Removal from State Mt 5-30-2009 Lansdown, MD Donation 5 Other Specify: ö 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H MDNorth Avenue Balto, 21202 1101 E. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician en Onset and failure. List only one cause on each line /Medical Death Gunshot Wound Of The Chest Immediate Cause (Final disease a. **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit nysician/Medical attending physician for use as the burial UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) signed by the atte I be detached for u Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 V No 3 Probably 4 Unknown Completed this certificate has been sidilificate, page 2 should be 24a. Was ar 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 ER/Outpatient 1 Yes After 28a. Date of Injury (Month, Day Year) May 23, 2009 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work Subject was shot Natural 0310 hrs Yes 2 V No Pending To the Funeral Director: completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or rown, State) 1801 East 28th Street, Baltimore, MD determined (Specify) Single Family Home 4 Momicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) May 25, 2009 O.C.M.E person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's

DHMH 17 Rev 1/2001 **OCMF 2006** 

State Registrar

Amend #20b, per Fh g892 6/8/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау **Physician** Month Year 2009 24 1:05a M Sherman Lee Cottrell 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5949 A Sunset Ave Social Security Number 6. Sex Baltimore
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □**X**M 2 □ F Yrs. **Director** 28 214-40-0831 67 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "Modical Evant not must be notified at Director 1√2Yes 2 □ No MD NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. Funeral 21207 5949 A Sunset 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married 3altimore, Maryland 21215-0036 1 ∐Yes 2√∑No Specify ģ Black 3 Widowed 4 Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder 12th grade Coastquard Yard na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be flik Iment of Health and Mental H Iant; If Item 27 is marked oth ပ္ Winslow Pinn Mary Ann Cottrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chong Cottrell-Wife 5949 A Sunset Ave, Baltimore, Md 21207 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important; If Ite any injury or ot 6/5/2009 1 

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Garrison Forest Vet <del>6/1/09</del> Owings Mills, Md 21. Signature of Euroeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, 21215 metle Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Due to (o as a consequence of): Infanct resulting in death) /Medical Examiner C Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner Dust dens necessorere of y perten (ou as a consequence of) attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, pe Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1º Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and fitte of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 726817 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Banthe) MD 10N. Gree 10 N. Greene St. Balt, more 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 26 200 na Craighead Ivory 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Union Memorial Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1□M 2□F MD 213-62-2016 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21218 825 Cador Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married 1 ☐ Yes 3√☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Unknown Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marjorie Gaskins George James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 825 Cador Ave, Baltimore, Md 21218 Danielle Craighead-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 6/8/09 Baltimore, Md 22. Name and Address of Facility 21. Si mature of Funeral Service Licenset March F/H West 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caus shock, or heart tailure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Intarchon lday Myo CArdia resulting in death)

/Medical Examiner physician the burial Division of Vital Records, P.O. Box 68760 has To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Modical Exemities must be notified at

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

**Physician** 

vithin 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b			
ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		pic pregnancy or (specify)		23d. Date of delivery Month Day Year
ed by Pr		ontributing to death but not resulting in the underly	-		co use contribute to the cause of death?  2  No 3 Probably 4 Unknown
Complete				24a. Was an autopsy performed 1 \(\summa\) Yes 2 \(\summa\)	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
ø	25. Was case referred to medical		26. Place of De	ath (Check only one)	
10 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Manpatient 2 ☐ ER/Outpatient 3[	□ DOA Other: 4 □ Nursing I	Home 5 ☐ Residence	e 6 ☐ Other (Specify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
Medical Certification:	29a. Certifier 1 Certifying Phr (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, death occi niner: On the basis of examination and/or investig and manner stated.	urred at the time, date and plac ation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
<u>≅</u>	29b. Signature and title of certifier	7.2	29c. License number	29d.	Date signed (Month, Day, Year)
		Breys M.D	D006316		nay 26, 2009
	30. Name and address of person who a	completed cause of death (Item 23a) (Type, Print) , MD Union Memorial Hage:	tel , 201 East Unions	inty Parkensuy !	Baltoner Maryland 21218

State Registrar

31. Date filed (Month, Day, Year)

Stephen Nguyen, MD

NS IBA CAPIAN KNOWN Maryland Baltimore,

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Bril **Physician** IDA CAPLAN 5 40 A M May إلى تعالى /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HUSPITAL OF BATIMORE CII N/A BALTINLORE Birthplace (State or Foreign Country)
 MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10/26/1916 Age (In yrs. last birthday **Funeral** Hours 1 □ M 2**V** F 217-66-6400 92 MD Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at Director 1 ¥Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 1803 THORNBERRY 21209 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: WHITE Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental CAPLAN HYMAN ANNIE ALBERT ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6061 PALMETTO CIRCLE NORTH BOCA RATON, FL 33433 FREIDA WEITZMAN / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other plane)
HAR ZION TIFERETH 20a. Method of Disposition Date 20c. Location - City or Town, State Pages Department of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HARÏZÏÖÑ 4 Donation 5 Dother (Specify) ROSEDALE, MD 05/24/2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS.. INC 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCHEMIC BUWEL **Physician** DISEASE DAY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown After this certificate has been si funeral director, page 2 should i 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Synature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 078 M NY 11/10010 VCIL 0009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 114-54-9369 70 Director 14 38 Italy Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 X Yes 2 □ No Examiner must be notified NH Piermont 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō Funeral 510 River Road Italy 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married X Married ☐ Yes Yes, Give 2X No Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2X No Specify White 2 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Cassadi Risparmio Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade U.S. Representative 6yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Giouanni Del Pozzo</u> <u>Maria Silvestrini</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5642 Main Street, Trumbull, Ct 06611 <u>Joan Patterson Del Pozzo</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Falconara Marittima 5/30/09 Ancora, Italy 21. Signature of Funeral Service Licensee 23a. Pal 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final My ocardial infarction Physician disease or condition /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day 4 Pregnant at time of death
9 Unknown 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) ၉ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural (Month, Day Year) 1 Yes 2 No 2 Accident M completely filled in by the **Director:** 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide the Hospital Funeral 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 State Registrar

09-04063

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			GDDd Samaritan Hospital	and nambor)		Baltimo					
	E	-	5. Social Security Number 6. Sex	7. Age (	In yrs. last birthday)	If Under 1	Year If Under 24	Irs. 8. Date of Bir	th(MM/DD/YYYY) 9. B Fore	irthplace (State or	
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		-	Jsual Residence of Decedent			<u> </u>					
	any	-	10a. State 10b. County	10	oc. City, Town or Loca	ation				10d. Inside City Limits	
_	*		MD N/A		Baltimor	е				1 X Yes 2 No	
20	arylar 8a-fs at on	ま	10e. Street and Number			10f. Zip Ci	ode	1	0g. Citizen of What Co	untry?	
14320	he M 1 or 2 iffed	Director	3605 Bateman Av	enue			216		USA		
I	death with the Maryland or items 23a or 28a-f show must be notified at once		T. Wanta otatao	Vas Decedent E	ver in U.S. 13. W	as Decedent	of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,	
	death r iten	Funeral	1 Never Married 2 Married	Yes 2	▼No				0*	Black	
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	136 hin 72 hours afte e. than "natural", edical Examiner		15. Decedent's Education (Specify only high		during	most of worki	ng life. DO NOT use	retired)	l con tand or admires		
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	withi withi giene.	Completed	17. Father's Name (First, Middle, Last)				18.Mother's N	ame (First, Middle,	Maiden Surname)		
	filed filed at Hyg ed off	BeC					Ophel	lia Shea	arin	n= 2000-1000	
	212 ald be Ments mark	0	William Donalds  19a. Informant's Name/Relationship (Type, F	rint )	19b. Mail	ing Address	(Street and Number	or Rural Route Nu	ımber, City or Town, Sta	ate, Zip Code) 21206	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Ophelia Carter-	Sister	57	78 <u>5</u> Ce	donia A		Apt A Bal	to, MD	
	e, health		20a. Method of Disposition	16 01.1	20b. Place of Disp crematory or		e of cemetery,	Date	20c. Location - City	or rown, State	
	ages nt of other		1 X Burial 2 Cremation 3 Re	emoval from Stat			al Pk 5	-27-200	9 Randall	stown, MD_	
	Baltimore, permit Pages I an Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		22	. Name and A	ddress of Facility	March	East F/H		
	Dep Dep Initia		Aladup	w our		1101	E. Nor	th Aven	ue Balro,	MD 21202 Approximate Interval	
	Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each lin	ns that caused t	he death. Do not ente	er the mode of	dying, such as card	iac or respiratory a	rrest, shock, or heart	Between Onset and	
7	'Medical		Immediate Cause (Final disease a. M	ethadon	e intoxica	tion				Death	
	xaminer		or condition resulting in death)  Due to	o (or as a conse	quence of):						
		-	Sequentially list conditions, if any, leading to immediate b.	o (or as a conse	quence of):						
		nin	Obsease or injury that initiated								
	si. q	n/Medical Examine	events resulting in death) Last  Due t	o (or as a conse	quence of):						
	certificate be executed carding physician and use as the burial - transit		d	23a	,2/,28a-t per ME g8	,perME	, g891 5/2	29/09 TT			
	O, s be ex sician sician burial			#1	per ME g8	92 6/8	/09 TT		23d. Date of del	very	
	376 ficate g phy s the b		23b. Was decedent pregnant in the	Live birth	ne of pregnancy	Fetal death	3 Ectopic p	regnancy	Month	Day Year	
	Box 6876 e death certificate the attending phy ed for use as the	cia	past 12 months?	Pregnant at	time of death 5	Other (Spec	ify)				
	Bo; deatl the atl	Physician/M	1 Yes 2 No 9 Unknown 9	Unknown			Dead	23a Die	tobacco use contribut	e to the cause of death?	
	tal Records, P.O. Box 6876 rian: The law requires that the death certificate certificate has been signed by the attending phy ector, page 2 should be detached for use as the	by P	Part II. Other significant conditions con-	tributing to death	but not resulting in t	ne underlying	cause given in Part			Probably 4 V Unknown	
	s, P		li					24a. W		re autopsy findings available	
	ords v requ shoul	je						au	topsy prior rformed? dear	r to completion of cause of	
	ecc he lav ate ha	Completed							s 2 🗸 No 1	Yes 2 No	
	Vital Recysician: The list certificate director, page	Be C	25. Was case referred to medical				26.Place of Death (C				
	Vita hysicia this co	을 일 일	examiner? Hospi	tal: 1 Inpatie	ent 2 🗸 ER/Outpat			Nursing Home 5		Other:	
	1 of V ling Phy After th			28a. Date of Inju (Month, Day,)	ry 28b. Time 'ear)	of Injury	28c. Injury at Work?	1 .	be how injury occurred		
	Sion Attendi r death rector: ,	읊	1 Natural 5 Pending 2 Accident Investigation	Fd 5/22	2/09 FD u	nk AM			n (Stroot and Number	or Rural Route Number, City	
	Division of Vital Records, ran after death and Attending Physician: The law requirers after death and Director. After this certificate has been sixeled in by the funeral director, page 2 should be	≗	3 Suicide 6 X Could not be	E/	njury - At home, farm,	street, factory .dence	, office building, etc.	or Tow	n, State)920 Dai Baltimore	or Rural Route Number, City	
	Divis	Certification:	4 Homicide determined	(Specify)			" Jala and also				
	Division of Vital Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certif completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: one) 2 Medical Examiner: On	To the best of me the basis of exa	iy knowledge, death o mination and/or inves	stigation, in my	eume, gate and plac popinion, death occu	e, and due to the d urred at the time, d	ate and place, and due	to the cause(s)	
	To th withi To th	Medical	29b. Signature and title of certifier	and manner stated.			c. License number			29d. Date signed (Month, Day, Year)	
12 1 A A . 200							O.C.M.E. May 22, 2009				
			mar.	-lated	Hooth (Itom 22a)						
	2 V		30. Name and address of person who com- Ling Li, MD Assistant Medi	cal Examine	er (1111 Penn S	treet, Balti	more, MD 2120	)1			
			111 41	-							
	Regi	State stra		Cens	ar's Signature	garke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23c Per Phy G891 5/27/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Ye ar Physician EONA 20 2000 MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. OHNS HOPKINS BAYUEM MEDICAL

5. Social Security Number 6. Sex 7. Age (In) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday **Funeral** Days (Month, Day, Year) 10/28/1925 Months Hours Min. 1 ☐ M 2 🔀 F 83 218-16-1494 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat roughts on conflict at any injury or other traumatic event, the Medical Examinat roughts of Dones. 1 ☐ Yes 2 K No Director Essex Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21221 Funeral 1504 Pattison Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victoria Dockins James Lewinski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13 Cornbury Court, Owings Mills, Maryland 21117 Christopher Douglass (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/26/2009 | Catonsville, Maryland Balto. Nat'l Cem. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hour Physician Due to ( r as a consequence of): /Medical Shoet 10 days Examiner ptic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( r as a consequence of): Examiner Sepsis burial-trar -Hන්නෙරා+1Division of Vital Records, P.O. Box 68760 $\frac{2}{2}$ Due to (or as a consequence of): physician a Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the Hospital or Attending Physician: The law requires that the death Month Day Year in the past 12 months? 5 ☐ Other (specify) □Yes 2□No signed by the a 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown icate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To After this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation Nithin 24 hours after community the Funeral Director: Aft 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number mil. RES-000 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H 4940 EASTERN AVENUE BALTIMORE, SEAN AGBOR-ENCH MD
31. Date filed (Month, bay, Year) PhD 32. F. gistrar's Signature State MAY 2 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Christopher Matthew Dolce State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death								9 16856					
		1- For State Registrar 1. Decedent's Name (First, Middle,Last)					12	Reg	g. No		3. Time of Death		
Physicia Medical Examir		Christopher Matthew Dolce					3	Month May 22, 20	Day Ye 09	ar	1050 hrs		
4a. Facility Name (if not institution, give street and number) 8911 Baltimore Street #B						4	b. City, Town, or L Savage	ocation of	Death		4c. County Howard		
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. las	t birthday)	If Under 1 Year	If Under	24Hrs.	8. Date of Birth	(MM/DD/YYY		nplace (State or
Director		212-90-6928	1 X M 2	F	3.	7 Yrs.	Months Days	Hours	Min.	May 6,	1972	Foreigr Cou	intry) Maryland
	ļ	Usual Residence of Decedent											10d. Inside City Limits
ow any		10a. State 10b. County				own or Locati	on					İ	1 X Yes 2 No
ryland ryland tit once	Director	MD Ho	ward			Savage	10f. Zip Code			10	g. Citizen of W	hat Coun	
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	<u>Pir</u>	8911 B Balti	more St	reet			207	63			USA		
with ms 23	eral	11. Marital Status	12. W		Ever in U.S		13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)					e - Americ	can Indian, Black,
r death wir	Funeral		1 Yes 2 X No				1 Yes 2 X No specify:				Specify		nite
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 77 is marked other than "natural", natic event, the Medical Examiner.	ğ	3 Widowed 4 D  15. Decedent's Education (Sp	or Dates	S:	npieted)	16a. Deceden	t's Usual Occupation	on (Give ki	nd of wo	rk done	16b. Kind of E		
5 72 hor n "na	eted	Elementary/Secondary (0-12	) Col	lege (1-4 or		during m	ost of working life.	DO <b>N</b> OT u	se retire	d) 1/1			1
5-0036 fled within 7/ Hygiene. I other than	Comple	12th	Ø			Lak	Laborer				UPS		
215-( be filed a ntal Hyg rked oth	Be Co	17. Father's Name (First, Middle	-,,	. Dola	_		1		,	First, Middle, M een 0'		<b>e</b> }	
212 212 Ould be I Menti mark		19a, Informant's Name/Relation	Robert  Ship (Type, Pri		е	19b. Mailing	Address (Street					wn, State	, Zip Code)
MD dd 2 sho llth and m 27 is		Kathleen O'Dol	ce /Mot	her			Park Av						
Ore, MI ges 1 and 2: of Health a if item 27		20a. Method of Disposition  1 Burial 2 XCremati	on 3 Rem	oval from St		ace of Dispos ematory or oth	ition (Name of cem ner place)	netery,		Date	20c. Location	- City or	Town, State
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		4 Donation 5 Other	Specify:				del Crem.			5/2009		ton,	
Baltimore, MD 21 permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex	1	21. Signature of Funeral Service	e Licensee	ar	MOl		ame and Address 3 Talbot		DO				ome, P.A.
Physician		23a. Part I. Enter the disease, failure List only one caus	or complications	that caused			ne mode of dying, s	such as car	rdiac or i	respiratory arre	st, shock, or h	eart	Approximate Interval Between Onset and
/Medical xaminer	ł	Immediate Cause (Final disease	1 C2354517				scular d			10401116			Death
j		or condition resulting in death)  Due to (or as a consequence of):											
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
be executed sician and urial - transit		events resulting in deathy Las	d.					71.	- /				
be exe	dical	X UNPENDED	AMEN	IDED 23	a,PII,	,27,pei	ME, g892	6/17	7/09	TT			
Box 68760 re death certificate I the attending phys		IF FEMALE: 23b. Was decedent pregnant in	23c.	If yes, outco	me of pregna	pa-mary	tal death 3	Ectopic	pregnan	cv	23d. Date Month		/ Day Year
ox 6. oth cert	sicia	past 12 months?  1 Yes 2 No 9 U	4	Pregnant a	t time of dea		her (Specify)						,
Box the death cy the atten	Phys	Part II. Other significant cond		Unknown	th hut not res	sulting in the I	inderlying cause di	iven in Par	+ 1	23e. Did to	bacco use cor	tribute to	the cause of death?
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Ć.	Chronic alco		uting to dear	ar but not rec	salang in the t	muenymy cause gr	ivenini a			parame	parameters.	pably 4 🗸 Unknown
rds, require been si tould b	eted									24a. Was a			itopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir rs after death all Director: After this certificate has been sited in by the funeral director, page 2 should to	Completed									perfor	med?	death?	
Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 st	o l	25. Was case referred to media						of Death (	Check or				
Vita	10 B	examiner? 1 ✓ Yes 2 No	Hospital:	T Impati		ER/Outpatient					Residence 6		r: Scene
n of		27. Manner of Death  1 X Natural 5 Pe		a. Date of Inj (Month, Day,)	ury Year)	28b. Time of I		y at Work? es 2		28d. Describe h	low injury occi	ırrea	
ivision or Attentate death Director:	icati	2 Accident Investigation 289 Place of Injury At home form street factory office huilding atc. 28f Location (Street and Number of Rural Route Number City								ıral Route Number, City			
Div	Certification:		uld not be ermined (S	pecify)						or Town, S	tate)		
To the Hospital Within 24 hours To the Funeral completely filled		29a. Certifier (Check only 1 Certifying	Physician: To	the best of n	ny knowledge	e, death occur	red at the time, da	te and plac	ce, and c	due to the caus	e(s) and mann	er as stat	ed.
withing 5 cmp.	Medical	one) 2 Medical Ex 29b. Signature and title of certi	and ma	basis of exa	mination an	d/or investiga	ion, in my opinion,		curred at	the time, date			nth, Day, Year)
		200. Organization and little or certification	111 11	,		*	O.C.N			OCME	May 23, 2		, Day, rear,
	-	30. Name and address of person	on who complete	ed cause of	death (Item :	23a)	,				L		_
$\varphi$		Theodore M. King, J	r., MD. A	-	/ledical E	xaminer	111 Penn Str	eet, Bal	timore	, MD 21201			
Sta	ate	31. Date filed (Month, Day, Yea		32. Registra	ar's Signatur	e							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20<u>09</u> Month 3:17 PM **Physician** May Donbert Louis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rosedale Franklin Square Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Months Days Hours 68 December 10,1940 Maryland 219-38-8449 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be redified at 1 □ Yes 2 □ Klo Director Essex Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 17 Avenal Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 21215-0036 Specify: White þ 1 and 2 should be filed within 72 hours Health and Mental Hygiene. em 27 is marked other than "natural"; 3 Midowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Transportation Truck Driver 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be ( Dorothy Meagher George Dorbert ౖ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Essex, Maryland 21221 Department of Health a Important; If item 27 is any injury or other tra once. Betty Klapka 17 Avenal Road. Companion 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State May 29,2009 Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of veral Service Lic 21222 Approximate Interval Between Onset and Death 23a. Patt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as consequence of): Examiner LONGL Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only onfuneral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. Ie Funeral Director: A bletely filled in by the fu death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hor To the Fune completely f 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Panayiotis Bo Forest Medical Center 8113 Harbord 12d Svite 100

DHMH 17 Rev 1/2001

State Registrar

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ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May **Physician** 200 7:27 PM George Dayton Dodge /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2007 Bear Ridge Road Baltimore Dundalk If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Months 1 X M 2 □ F 80 7-27-1928 Director 235-38-9359 WV Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evaniner must be notified at 10a. State 10b. County 1 XYes 2 □ No Director Baltimore MD Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 2007 Bear Ridge Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Ves 2 ☐ No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Mechanic Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Ezea B. Dodge Dessie G. Shaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1794 19a. Informant's Name/Relationship (Type. Print) Doris Vangunsteren-Baughter 14131 Rover Mill Rd., West Friendship, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iter any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Bayview Crematory 5-26-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bradley-Ashton Funeral Home PA, 2134 Willow Spring Road, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a Respiratory rallure disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** End Stage Chronic Obstructive Pulmonary Discus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 1 ☐Yes 2 ☐ No 9 DUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 📝 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 124 hours after death.
 e Funeral Director; A letely filled in by the full 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

State

within 2.

Medical

29a. Certifier (Check only

29b. Signature and title of certifie

35

29d. Date signed (Month, Day, Year)

Smith Ave Suite 203 Baltimore MD 21209

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month ALLAN CORNELIUS DRIVER IT. 25 MA 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 145WARD HOWALD LOVNTY SCHOLLER HOSPITA CULUMBIA 8. Date of Birth (Month, Day, Feb 19, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Months Hours **½** M 2 □ F 1938 71 MD 212-34-4801 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Marriottsville Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21104 1320 Driver Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status 1 ∐Yes 2 ∭XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Straten Allan C. Driver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1320 Driver Road Marriottsville, MD 21104 Mrs. Lee Ann Driver (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD Crest Lawn Mem. Gardens 5/29/09 HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC 51452K 20245 disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

of Health and Mental Hygien of Health and Mental Hygien transfer other transmatic event, the

Department of H Important: If Itel any Injury or oth

**Physician** 

/Medical

10a. State

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Director

Funeral

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Completed

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Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner rust be nutified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours aft

To the Funeral Di

completely filled in

Division of Vital Records, P.O. Box 68760,

	h PRSCESS MEST	2 WEEKS				
Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).					
that initiated events ' resulting in death) Last	C. Due to (or as a consequence of):					
IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		topic pregnancy her ( <i>specify</i> )	23d.	Date of delivery Month Day Year		
NEWTO RETURNE	contributing to death but not resulting in the under	lying cause given in Part I.	10	contribute to the cause of death?		
MWT& Nosmi	examy private		24a. Was an 24 autopsy performed? 1 □ Yes 2 ☑ 100	4b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No		
25. Was case referred to medical		26. Place of Dea	th (Check onl one)			
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Conpatient 2 ☐ ER/Outpatient 3	Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐	Other (Specify)		
27. Manner of Death 1 Shatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred			
3 Suicide 6 Could not be 4 Homicide determined		factory, office	28f. Location (Street and No City or Town, State)	umber or Rural Route Number,		
	niner: On the best of my knowledge, death oc niner: On the basis of examination and/or invest and manner stated.					
29b. Signature and title of certifier		29c. License number	29d. Date si	29d. Date signed (Month, Day, Year)		

1) 36974

2009

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10 V

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

10724 UTTLE PATUKENT ww 32. Registraris Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.MYMISM

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25, May Month 2009 12:15A M Emilie DeWeese 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Dundalk Baltimore Genesis ElderCare-Heritage 8. Date of Birth NOV14, 1919 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Days Hours Min. Months Ohio 1 □ M 2 🖫 F 89 213-09-2912 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c, City, Town or Location 1 ☐ Yes 2 ☐ No Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21222 U.S.A. 203 Cleveland Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2€ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Beth Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Matthew Sakowski Mary Anna Kutz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 205 Cleveland Avenue Baltimore, Md. 21222 Robert DeWeese (son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 5-29-2009Baltimore, Maryland Christ Lutheran 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facili Kaczorowski Funeral Home, P. A 21. Signature of Funeral Service Lie Dundalk Avenue Baltimore, Md. 1201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter thide lying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

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Director

Funeral

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Completed

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**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat mast be notified at once.

Baltimore, Maryland 21215-0036

Examiner sician and burial-trans physician at the burial Physician/Medical attending p signed by the a Be Completed by certificate has been si rector, page 2 should I Medical Certification: To after death Director: A

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1 □ Yes 2 KINO 9 □ Unknown	9 Unknown		,,,						
Part II. Other significant conditions of	ontributing to death but not res	23e. Did tobacco use contribute to the cause of deat							
				1 ☐ Yes 2[	☐ No 3 Probably 4 ☐ Unknown				
				24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient 3 □	DOA Other: Will Nursing I	Home 5 ☐ Residence	6 ☐ Other (Specify)				
27. Manner of Death 1 M Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)		18f. Location (Street and Number or Rural Route Number, City or Town, State)					
	ysician: To the best of my kno				) and manner as stated.				

29c. License number

27188

29d. Date signed (Month, Day, Year)

2009

May 26,

State Registrar

DHMH 17 Rev 1/2001

within 24 hours aft To the Funeral Di completely filled in

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Savinder K. Julka, M.D. 2 Market Place Dundalk, Maryland 21222 32 Registrar's Signature

and manner stated

			1 _ State				2000	16861
п			Registral     Decedent's Name (First, Middle, Last)	imouto or i		2. Date of Deat	h	3. Time of Death
	Physicia /Medic				l diamet Dank		, 2009	9:52 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Lorien at Bel Air				Harford	tui
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bin C 1914 Ma	rthplace (State or Foreign ountry) rvland
	Director	i	Usual Residence of Decedent			03/23/	1714 110	
	f show	ō	MD Harford Bel Air	cation				1 □Yes XX No
	r 28a-	irect	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What C	ountry?
	ath wit	Certificate of Death   Segment   S						
320	rs after death with the Maryland I', or items 23a or 28a-f show rain for must be notified at	by Fune	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 22 ☐ No If Yes, Give			Rican, etc.)	Black, Whi	te, etc.
315-UU36	iin 72 hou . "natura cical E	pleted	15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work f)	ing		
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Mary	nd 2 shouli ilth and Me 27 is mark traumati	ř	19a. Informant's Name/Relationship (Type. Print) 19b. Mailir					Zip Code)
more,	Pages 1 ar tent of Hea nt: If item		1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Gardens 6	matory or other plac of Faith	Cem 05/22	2/2009	Baltimore	, MD
Baitimor	permit. Departm Importa any inju		21. Sign sure of Funeral Service License 22					The state of the s
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dyir	ng, such as cardiac	or respiratory are	rest,	Interval Between
	Physician /Medical		disease or condition a. Dementia End Sta	ge				
	Examiner	L						
	uted  -  nsit	mine	if any, leading to immediate Due to (or as a consequence of): eause. Enter Uncerlying Cause (Disease or injury					
8/60,	ficate be executed physician and s the burial-transit	al Exa	resulting in death) Last  C.  Due to (or as a consequence of):					
	rtificate ng phys as the	Nedic	0.					
O. BOX	w requires that the death certific been signed by the attending p should be detached for use as	/sician//	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐  4 ☐ Pregnant at time of death 5 ☐		y		3.7	·
ds, P.	requires that the been signed by th hould be detache	ğ	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause giv	en in Part I.			
Yec Y	as 2	omplete				autop perfor	sy prior to med? death	o completion of cause of ?
	ding Physician: The h. h. After this certificate h funeral director, page		examiner?	Ott		th (Check only or	ne)	
5	Physi er this c eral dire	2:	27 Manner of Death 28a. Date of Injury 28b. Time of	nt 3 🗆 DOA	4 LA Nursing H			pecify)
10 n	ending sath. or: Afte he fune	ation	2 Accident investigation					
DIVISION	al or Attending F s after death. al Director: After ed in by the funer	Certific	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide	reet, factory, office		28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		(Check only 2 Medical Examiner: On the basis of examination and/or in	th occurred at the t nvestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	vithi To th	Ž	29b. Signature and title of certifier					
			30. Name and address of person who completed cause of death (Item 23a) (Type,	, Print)		MD 210		
F	Sta		31. Date-filed (Month, Day, Year) 32. Registrar's Signature					
	Registr	rar	MAY 27 2009 Ceneral S. Janes					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** door /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreigr Country) Social Security Number Age (In yrs. last birthday) 6. Sex **Funeral** 1 **X**M 2 □ F 92 03 09 Director 242-14-5669 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified a once. Director Randallstown MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 8944 Harkate Way 21133 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎇 No <u>م</u> Specify: Black 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) National Security College (1-4 or 5+) Elementary/Secondary (0-12) Agency Chauffeur 8th grade 18. Mother's Name (First, Middle, Maiden Surnai 17. Father's Name (First, Middle, Last) Be Joe Rogers Edwards Sallie Moore ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vivian Paysour -- Daughter 20a. Method of Disposition 20 Harkate Way, Randallstown, Md 21133 osition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Garrison Forest Vet 6/2/09\_ Owings Mills, Md of Funeral Service Lice 22. Name and Address of Facility March F/H West ture 23a. Pa. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, 21215 Approximate Interval Between Onset and Death 515 Imm diate Cause (Final **Physician** die ase or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam The law requires that the death certificate be executed the burial-transi that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No . Yes 2 🗹 No 1 TYes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🏿 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No 2 ER/Outpatient 3 DOA မ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No after death. filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide

Division of Vital Records, P.O. Box 68760, or Attending

within 2 To the I

State Registrar

29c. License number Res-000

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

f 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2009 May, 24

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD teven

and manner stated.

600 North Wolfe St, Baltimore, MD, 21287

31. Date filed (Month, Day, Year)

29a. Certifier

one)

(check only

29b. Signature and title of certifier

Medical

32. Registrar's Signature

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 22 Eley, James E. Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City sinai hospital of Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Eley Days Hours 1**√** M 2□ F 53 11-7-1955 Director 214-64-4320 Usual Residence of Decedent 10h County 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Medical Examinar must be notified at Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 6 23a 21218 USA 2010 E. 31st Street James Funeral 14. Race - American Indian, Black, White, etc. items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No "natural", or Specify: δ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Saint Joseph permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Food Service Hospital 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KNOWN Be James E. Eley, Sr Evelyn I. Peoples 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Royce Eley-Brother 2010 E. 31st Street Balto, MD 21218
of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Western Star Cem 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5-29-09 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H 1101 E. North Avenue Balto, MD wou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final DIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Seps is Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Cardrac arres and Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Division of Vital Records, P.O. 9 Unknown To the Hospital or Attending Physician: The law requires that the a within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1☐Inpatient 2☐ER/Outpatient 3☐DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Sinai hospital 32 Registrar's Signature

Gra

600 Ca

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES -000

Batmere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Vear

2009

NA

16:04

MD

10d. Inside City Limits

21202

Approximate Interval Between Onset and Death

day

Month

29d. Date signed (Month, Day, Year)

221

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

1X Yes 2 □ No

Birthplace (State or Foreign Country)

Black

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** May 23,2009 1:50P Katherine M. Friesser /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Balto. 24 Bangert Avenue Perry Hall Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 💆 F Yrs. 13,1927 Maryland 82 February Director 219-18-6931 Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examination and once. 1 ☐ Yes 2 No **Funeral Director** Balto. Perry Hall Md. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21128 USA 24 Bangert Avenue 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🎾 No White Specify: 2 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Reading Specialist Elementary/Secondary (0-12) College (1-4or 5+) Primary Education 12 Teacher 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17 Father's Name (First, Middle, Last) Be Anna Kocyan John Wisniewski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kingsville, Md. 21087
Date 20c. Location - City or Town, State 7431 Mt. Vista Rd. <u>Michaelen LeHew</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-27-2009 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) anislaus 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MONTH **Physician** Now disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy performed 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 Z No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred funeral After 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie (It) m 23a) (Type, Print) OSLER DRIVE SUITE 101

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Funderburk Margieleno 2009/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner sedale Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Rountry) Days Months 1 □ M 2 🗗 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 should be filed within 72 hours after death with I and Mental Hygiene. Calda 12. Was Decedent Ever in U.S. Armed Forces? 1 Dyes 2 No Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Funderburk, Margit lent Baltimore, Maryland 21215-0036 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☑ No Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Nurses ssistand 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Israel Bane ၉ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Funderbur of Health 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition Department of Important: If It any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State VINITY CEMETER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician at the burial-Box 68760, Physician/Medical attending pl for use as t IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 ¥Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Many er of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ho Anne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HO, Bathmore MD 21237

Registrar

State

31. Date filed (Month, Day,

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 7528 FORREST 2009 21 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTEMORE OF MARYLAND MEDICAL CUTR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 7, 1923 Birthplace (State or Foreign Country) **Funeral** Months Days Hours XXM 2 F 85 Maryland 215-18-6193 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f show the Medical Exeminer hust be notified at 1 ☐ Yes 2 ☐ No Maryland Harford County Director Forest Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Pages 1 and 2 should be filed within 72 hours after death with United States 718 Walters Mill Road 21050 items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify: White Specify: δ 3 Widowed 4 NDivorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: if item 27 is marked other the any Injury or other traumatic event, it at 900. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin A. Forrest Pearl Dushe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Jane Kuchne (Daughter) 3610 Miller Road, Street, Maryland 21154 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 0 5/26/2009 Green Mount Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PANCREATITIES 4 CUITE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □ No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DISEASE ARTERY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 ☐ Yes 2 No certificate 2 🗆 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this I Director: After this ad in by the funeral d Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the I within 2 To the I complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AU4176435M19078 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Nurana

27 2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

S. GREENE ST BALTEMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 16867 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 23, **Physician** Charmaine S. 11:45 AM Green /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hunt Valley Baltimore 11833 A Falls Road If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth Month, Day Year 6/10/1928 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Ohio 1 □ M 2**/C**XF 298-22-5964 Yrs. 80 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Hunt Valley 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21030 23a 11833 A Falls Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: Specify: White δ 3 XWidowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( John Stillion Helen Myers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health a Important: If Item 27 Is any Injury or other trau once. 11833 A Falls Road Hunt Valley, Maryland 21030 Cynthia Lanzi /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv. Corp. 5/27/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 ral Home, Inc. 1050 York Road 21. Signature of Euneral Service Licensee Ruck Towson Funeral Homé, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2.21No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Yeer) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C the Hospital 1 Socertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

MAY 27 2009

JulieRBr

31. Date filed (Month, Day,

erMD 1650 Orteans Street 132. Registrar's Signature Linux S. gard

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

		a .	For State Registrar	State of Maryland / Depa	artment of Health and M tificate of Death	Reg. N	2005 1000	8
	Physicia	an	1. Decedent's Name (First, Middle, Last)  William Gr	iffith		2. Date of Death Month D May 2	Day Year 75/	M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		Ic. County of Death	
		Ĭ.		spital	Randollstown	10.0	Baltimore	-/
	Funeral Director		5. Social Security Number 6. Sec. 18-12-9837	7. Age (In yrs. last birthday)  M 2 F 90 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea April 21,	9. Birthplace (State or Fore Country) 1919 Maryland	∌ign
	ס		Usual Residence of Decedent	10c. City, Town or Lo	cation		10d. Inside City Lim	nits
	Aarylau F show	ō	Md. Baltimor				1 □ Yes 2 🔀	
	r 28e-	Funeral Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?	
	th with	ai D	3405 Croydon Ro		21207		USA	
	er dea	unei	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- po Rican, etc.)	14. Race - American Indian, Black, White, etc.	
036	tiled within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28e-f show ent, the Medical Examinant han notified at	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No Specify:		Specify: Black	
21215-0036	"natur	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. Decede (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b.	Kind of Business/Industry	
712	iene. r then	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ Teacl			Education	
פ	al Hyg	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	an Sumame)	
Maryland	ould by Ment	2	John Griffith	Oriest 10b Maille	Theresa		v or Town State 7in Code)	
<u>ā</u> <b>≥</b>	od 2 st lth and 27 is n treun		19a. Informant's Name/Relationship (7) Mrs. Kimberly Demp		05 Croydon Rd. Gw			
re,	of Heal		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)		Location - City or Town, State	
Baltimore,	ment in the fact of fury or		1 ⊠ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Resurrec			linton, Md.	
Ball	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if them 27 is marked other than "natural", or items 23a or 28e-1 show any njury or other treumatic event, the Madical Examinal must be notified at another.		21. Signature of Fundral Service Lines	22	2. Name and Address of Facility RUCK TOWSON F 1050 York Rd.			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the death. Do not ent ne cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death	1
5	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Kespiraton)	failure		160 hair	
	Examiner			Due to (or all a considuency of):			~ 60 haus	
	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	1 / / /		10/	_
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	Infarction		~ 60 hours	7.
8760,	et sys	cal		d. Hypotension			- 48 hours	2
89 X	death certificat e attanding phy d for use as th	/Med	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery	
.O. Box	0 0 0	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		Month Day Year	
<u>α</u>	that the ed by detacl	/Ph		ntributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death	?
rds	= v T	ed b	Endstage Renal d	siase, encepholopo	thy, sepsis,	1 ☐ Yes	2 No 3 Probably 4 ☑Unkno	own
Vital Records,		uplet	coronan artery dis	ase, ofrial fibrilla	ation, peripheral	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause death?	able
al H			arterial distase,	hepatic congestion	<i>N</i>	performed		
₹	ding Physician: h. Ater this certific funeral director.	To Be	25. s case referred to medical examiner?	Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatien	Other	ath (Check only one) Home 5 ☐ Residence	e 6 □Other (Specify)	
n of	ng Phy Iter thi neral o		27. Manner of Death 1 DNatural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in		
Division	Attending r death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, st	M 1 Yes 2 No	28f Location (Street	t and Number or Rural Route Number,	
20	el or Attendes safter deatl	Certification:	4 Homicide determined	building, etc. (Specify)	real, factory, office	City or Town, St		
6	To the Hospitel or Attent within 24 hours after deat To the Funerel Director: completely filled in by the	ledicai (		rsician: To the best of my knowledge, deal iner: On the basis of examination and/or in and manner stated.				
1	To the within To the comple	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)	
			# HINT DO	)	H0068505		May 23, 2009	
			30. Name and address of person who o	ompleted cause of death (Item 23a) (Type	Print)		/	
	St: Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	les .			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ug Og **Physician** 7:08 PM HARVIN ARRY 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 **X** M 2 □ F MARCh 31, 1959 218-74-1765 Director Usual Residence of Decedent 10d, Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ♣No Director BALT, none 6 wing mulls 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 23a or U15,A 10808 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items 11. Marital Status Armed Forces? PITING A Yes 2 NORET REAL Yes, Give AIR Force Year or Dates: 1917-2000 1 Never Married Married Baltimore, Maryland 21215-0036 2 No Specify Specify: Black 1 TYes ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) G-OVERENT Elementary/Secondary (0-12) College (1-4 or 5+) echNican 9RAde 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau her CARD Wings 11:115 MD 21117 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) bodlawn Cem DAHINOTE, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CAROLINE ST. 112911. Approximate Interval Between Onset and Death 239. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intracerebral Hemorrhage hours **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine use as the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗆 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☐ No 3 ☐ Probably 4 XUnknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed?
Ves 2 No 2 🗌 No 1 TYes Yes 26. Place of Death (Check only one) I or Attending Physician: after death. 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1X Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Deat Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 4 - Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 09 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharrief 600 North Wolfe St, Baltimore, MD, 21287 MD Anjai 1 31. Date filed (Month, Day, Year, State

Registra DHMH 17 Rev 1/2001

Box 68760

09-03997	
John W. Hammond	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
amend #10a Per FH 6893:71/20/69

2009 | 16870

			For State	amen	d #1Ua Pe	ET TH	39 itilica	te of	9eath	n 				g. No.		In Town of D	- ath
_	Physicia		egistrar . Decedent's Name	e (First, Middl	e,Last)							2.	Date of Deat Month	h Day Y	'ear	3. Time of De 2130 hr	
Med	ical Examir	-	John W.		_								Month May 19, 20	009			
			la. Facility Name (i	if not institutio	n, give street and r	number)		4t	. City, To	wn, or Lo	cation of	Death		4c. Couri	ty of Deat	h	
			4 Water Str					- 1	Charle	stown				Cecil			
			5. Social Security		6. Sex	7 Age (In	yrs. last birth	iday)	If Under	1 Year	If Under	24Hrs.	8. Date of Bir	th (MM/DD/YY	YY) 9. Bi	rthplace (State	or
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00	rylar	왕	10e. Street and Nu	ımber					10f. Zip	Code			1	0g. Citizen of			
14248	ne Maryland or 28a-f show any fied at once.	Director			, Slip 1	1				2191	4			United	1 Sta	ites	
7	th th 23a noti		11. Marital Status			ecedent Eve	r in U.S.	13. Was	Deceder	nt of Hisp	anic Origi	in? (Spe	cify Yes or No			erican Indian, E	lack,
	th w	unera	1 Never Marr	ied 2 X M	Armed Armed	Forces?		lf Y∈	es, specify	/ Cuban,	Mexican,	Puerto R	tican, etc.)	"	/hite, etc.		
	or it	필			1 X Yes	2		1	Yes 2	Y No	specify:			Speci	ify: V	Mite	]
	afte	<u>a</u>	3 Widowed		or Dates: ecify only highest g		od) 16a	Decedent	's Usual (	Occupation	on (Give I	and of wo	ork done	16b. Kind o	f Busines:	s/Industry	
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	O3	Completed						LINCL	uacı				First, Middle,	Maiden Surna	ame)		
	5-0 led v Hygin othe	ပိ	17. Father's Name											anrode			1
	21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Be	George				140	1 1 - 11	A 444	(Ct+++++	nall L	Lec .	ural Route Nu	ımber, City or	Town, Sta	ate, Zip Code)	
	21 ould d Me s ma si ev	<u>د</u>	19a. Informant's N														
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	e, land Healt item		20a. Method of Di	sposition		16	20b. Place cremat	of Dispos tory or ot	ition (Nar her place	ne of cen	netery,		Date	200. 2000.	,		
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		_		on 3 Remov	al from State					eter	v 05	/27/20	09 Lan	caste	er, PA	
	Limen trmen reami		4 Donation 21. Signature of	5 Other	Specify:	. Harm		22.1	lame and	Address	of Facilit	y Ch	arles	F. Sny	der.	Jr. Fu	neral
	Sal ermi bepar mpol		21. Signature of	Uligial Service	e Licensec 1	· Halin	an									titz, P	
	<b>m</b> 20 = 15	_	100	1	or complications th	at caused the	death. Do n	ot enter t	he mode	of dying,	such as o	ardiac or	respiratory a	rrest, shock, o	r heart	Approxin	nate Interval
	Physician		failure. List of	only one caus	se on each line.	at daddod tild					1		10~	dicas	CO		Onset and Death
100	/ dedical aminer		Immediate Cause		se on each line. se a. <b>Hype</b> 1	tensi	ve ath	eros	lero	tic	cara	lova	Scular	uisca	<u> </u>		
1	/		or condition resu	Iting in death)	Due to (or	as a cons <b>equ</b>	ence of):										
			Sequentially list	conditions,	b		enes of):										
0		ner	if any, leading to cause. Enter Un			as a consequ	ience or).									1	
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	tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and error name 2 should be detached for use as the burial - transit	cal	X UNPENDE	-D	AMEND	<sub>ED</sub> 23a	,PII,2	27 <b>,</b> pe	erME,	G89	2 6/	22/0	9 TT				
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	e law	ΙĔ												s 2 No	1 🗸	Yes	2 No
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	Afte	=	1 X Natural			Month, Day,Yea	ar)			1	Yes 2	No	1				
	itend leath tor:	Certification:	2 Acciden		ending rvestigation					- office	huilding	etc	28f Locatio	on (Street and	Number	or Rural Route	Number, City
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	pital o	1	4 Homicic	ie .		ecify)				_	_		1				
	Di To the Hospital within 24 hours. To the Funeral			Certifying	g Physician: To th	e best of my	knowledge,	death occ	curred at	he time,	date and	place, an	d due to the	cause(s) and r	nanner as	s stated. • to the cause(s	(2
2	the J	Medical	one) 2	✓ Medical I	Examiner: On the b	asis of exam ner stated.	ination and/o	or investig	gation, in	my opinio	on, death	occurred	at the line, t	zate and place	, and acc		
on	To With	3 8	29b. Signature	and title of ce		iner states.			- 1	29c. Lice	nse numb		0110		_	(Month, Day,	Year)
Or,		-	-1	1	71 -	V: ,	<u> </u>	\		0.0	C.M.E.	0	CME	May 2	20, 200	9	
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	~	4			rson who complete	d cau elof de sistant Me	eath (Item 23	a) miner	111	Penn S	Street. F	3altimo	re, MD 21	201			
	Ø V			e M. King,		Α				. 5							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:58 a M May 25 2009 Lenora R. Harris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore FutureCare Sandtown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2√2 F 95 220-82-0814 4/2/1914 Director SC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at N/A 1√2Yes 2□No Baltimore Directo MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 845 N. Bentalou St. 21216 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status African 1 Never Married 2 Married 1 ☐ Yes 2X No Specify ð 3 Widowed 4 Divorced Ämerican Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk unk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Benjamin Steven/Son 7400-A Castlemoor Rd, Balt., MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Balt., MD 3 Removal from State Bayview Crematory 6/1/09 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA. 21. Signature of Funera Service Licensee 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician senier disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,&and burial-trar attending physician the been signed by certificate has been signi rector, page 2 should be or Attending Physician: this funeral the 1 hours after death uneral Director: filled in by within 24 hours a

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Medical Certification: To

5 Pending

investigation

determined

30. Name and address of person who completed cause of death (Item

Year

2009

6 ☐ Could not be

2 ☐ Accident

4 Homicide

(Check only

29b. Signature and title of certifier

filed (Month, Day,

3 ☐ Sulcide

State Registrar

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

23a) (Type.

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg No 2 0 0 9 1 6 8 7 2							
		_		06/	incate of Death			. No.		
				5				2009 2009	23:50 M	
			, ,	·						
a port							Data of Distle			
			1 M 2 TVF	ge ( <i>In yrs. last birthday</i> ) 86 Yrs.	Months Days Hours	Min.	(Month, Day, Y	ear) Cou	intry)  MD	
			Usual Residence of Decedent							
rylan	works 1 at	San .	10a. State 10b. County	10c. City, Town or Lo	cation					
e Ma	Ba-f s	cto	MD Howard	Certificate of Death  Neg. 16.2  Death of Death  Hines Hobbs  Ac Cast Town of Location  Ac Cast Town of Location  Olney  Olney  Montagomery  Montago						
with th	a or 2 be re	Dire		Certificate of Death    Control Death   Contro						
eath v	rs 23; count	eral		Certificate of Death   Serve (Prest, Modes, Last)   Evelyn Hines Hobbs   2 and 1 a						
ufter d	r iten iner	Fun	Armed Forces 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐	Certificate of Death  Control Planes  Control						
onrs a	ral",o Even	l by		Certificate of Death    Control   Co						
72 hc	natn	etec	15. Decedent's Education (Specify only highest grade completed)	Certificate of Death  Region (First, Middle, Last)  Evel Lyn Hines Hobbs  40. Chip Tean or Location or Death  Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  3, 17 for of Death Ray 2, 2679, 2009  4, 17 for of Death Ray 2, 2679  4, 17 for of Death Ray 2, 2679  4, 17 for of Death Ray 2, 2679  4, 17 for of Death Ray 2, 2679  4, 17 for of Death Ray 2, 2679  4, 17 for of Death Ray 2, 2679  4, 17 for of Death Ray 2, 2679  4, 17 for of Death Ray 2, 2679  4, 17 for of Death Ray 2, 2						
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			1 - Stata Registrar	Maryland / Dep Co	partment of I	Health and Death	R	eg. No.	16873
\$	Physici		1. Decedent's Name (First, Middle, Last)  Kenneth Hubert				2. Date of Dea Month May	Day Year 2009	3:00a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number	r)	_	or Location of Dea	th	4c. County of Death	
0	Dig.	- 12	Future Care - Cherrywood  5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthda	Reister:		8. Date of Birth	Baltimore	
,34	Funeral Director		107-16-1505 1 <sup>1</sup> √x <sup>M 2□ F</sup> 9:		Months Days			1916 Coul	place (State or Foreign ntry) NY
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				Od. Inside City Limits
	Maryl	tor	MD Carroll	Sykes	ville				1 ☐ Yes 2 XNo
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other then "natural", or items 23a or 28a-f show amply injury or other traumatic event. The Medical Example multiple in an ance.	Funeral Director	10e. Street and Number 2012 Sherryl Avenue		10f. Zip Code 21784		1	Og. Citizen of What Coul USA	ntry?
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9	2 hou	ted t	15. Decedent's Education	16a. Dec	cedent's Usual Occu	pation	advin a	16b. Kind of Business/In	
21215-0036	within 7 ne. hen *r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4o)	r 5+)	ve kind of work done DO NOT use retire	ed)	orking	education	
q 7	filed v Hygie Other t ent, th	e Co	O 17. Father's Name (First, Middle, Last)		custodian	18. Mother's Na	me (First, Middle,		
ylan	Mental Mental Brked o	To Be	August Hubert			Adaline	Menkin		
Maryland	d 2 sho th and 7 ie mu traumu		19a. Informant's Name/Relationship (Type, Print) Timothy Hubert (son)					, City or Town, State, Zij , MD 21784	Code)
<u>.</u>	s 1 and Heall item 2		20a. Method of Disposition	20b. Place ol Dis	position (Name of rematory or other pla		Date	20c. Location - City or To	own, State
<u>E</u>	Page ment o ant: if ury or		1 🖾 Burial 2 □ Cremation 3 ☑Removal from Stat 4 □ Donation 5 □ Other (Specify)	Calvary	Cemetery	5-2		Youngsville	
Baltimore,	permit. Departimport any inj		21. Signature of Funeral Service Licensee  Page Haight Herbee		22. Name and Addr P.O. Box			eral Home & D 21784	Chapel
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	To the Hospital within 24 hours a To the Funerei I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best and manner.	of examination and/or	eath occurred at the investigation, in my	time, date and place opinion, death occ	ce, and due to the courred at the time, of	ause(s) and manner as state and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of perifier		29c. Licer	nse number	à	29d. Date signed (Month,	Day, Year)
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K	) 1		30. Name and garess of person with completed cause of	ttt Cm	ee, Print)	838	Sen	Tree	Refrirs
Service of the servic	Sta Registi		31. Date filed (Month, Day, Year)  MAY 27 2009	strar's Signature	who				\

			State of Maryland	•	ment of H <i>icate of L</i>			Iene ∍g. No. ↑ ↑ ↑ ↑	1 6 0 71 1
	_		Registrar  1. Decedent's Name (First, Middle, Last)				Date of Death     Month	/_	3. Time of Death
	Physici /Medic		Blanche M. Hines					2, 2009	6:50PM
	Examin	er	4a. Facility Name (If not institution, give street and number) Fairhaven Health Care Center	4b.		Location of Death		4c. County of Deat	<sup>h</sup> arroll
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 206–26–9209		Under 1 Year onths Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, July 24	Year) 9. Birt	hplace (State or Foreign untry) Canada
	/land			Town or Location					10d. Inside City Limits
	Ba-f sh	Director	MD Carroll		Sykesy	ville			1 □ Yes 🔏 □ No
	ath with th	ral Dire	10e. Street and Number 7200 Third Avenue		0f. Zip Code			0g. Citizen of What Co	
9036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show officel Evantiner must be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		Decedent of His, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto F Specify:			hite
Maryland 21215-0036	c 2 6	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2	16a. Decedent' (Give kind life. DO N	's Usual Occup I of work done o NOT use retired	during most of workin		16b. Kind of Business/	Industry
/land	should be filed within and Mental Hygiene. s marked other than umatic event, Ire M	To Be C	17. Father's Name (First, Middle, Last)  John R. Hartree			18. Mother's Name  Leda F		Maiden Surname)	
Mar	12s har 7 is trau		19a. Informant's Name/Relationship (Type. Print) Mr. Emmett W. Hines, Jr. (Spouse	_				City or Town, State, 2	
	es 1 and 2 of Health item 27 i		20a. Method of Disposition 20b. Plac	ce of Disposition netery, cremato				20c. Location - City or	
Baltimore,	Pages tment of tant: If it		1 ☐ Burial 2 Decremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	County	Cremati	ion   5/23/		Sykesville	, MD
Bal	permit. Pages: Department of I Important: If its any injury or o		21. Signature of Funeral Service Licensee  Sum L. Hou de Moo?	68 PO	GHI FUN Box 195	TERAL HOME Sykesvil	& CHAP le, MD	EL, PA 21784	
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.		•			4	Approximate Interval Between Onset and Death
Arabar .	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequent of the conse	nce of):	wasm	eall cell	Cung	Cancier	Fall of 104
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68760,	ificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last  Due to (or as a consequent of d.	nce of):					
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S, P.	ires that signed by	by Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the under	lying cause give	en in Part I.		pacco use contribute to	
ord	w require been si should b	ed					-		robably 4 Unknown
of Vital Records,	The law cate has b page 2 s	Completed					24a. Was a autops perforr	y prior to ned? death?	utopsy findings available completion of cause of
/ital	siclan: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death			2
<b>d</b>	Phys	၉	1 Yes 2 Hospital: 1 Inpatient 2 EF	R/Outpatient 3		4 Nursing Hor		ence 6 Other (Spe	ecify)
ion	Attending Ph r death. ector: After th by the funeral	ation	1 Matural 5 □ Pending (Month, Ďay, Year) 2 □ Accident investigation	lnjury	28c. Injur Worl M 1 □	k? Yes 2 □ No			
Division	i di di	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, street,	factory, office	2	28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
	e Hospital 124 hours e Funeral letely filled	edical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowled to the process of examination one)  Nurse Practant Transferated.	edge, death oc on and/or invest	curred at the til tigation, in my c	me, date and place, a ppinion, death occurre	and due to the o ed at the time, d	cause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the I within 2.	Me	29b. Signature and title of certifier		29c. Licens		2	9d. Date signed (Mont	th, Day, Year)
	0 .		30. Name and address of person who completed cause of death (Item 2	CUNS		41230		5/23/0	9
	8 V		Phy 1/15 C. SHAND CNNP		-Cebeni	4 20			
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signatur	re		/	Y		
DH	MH 17 Rev 1/2		MAY 27 2009 Sener S. A.	arks	INIAI				· · · · · · · · · · · · · · · · · · ·

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 12:00PM May Luther Leroy Johnson III /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8903 Allenswood Road Randallistown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Ye 8-20-1951 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** X□M 2□F Months Days Hours Min 57 212-58-6904 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Randallstown Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 USA 8903 Allenswood Road Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: specify: African-American \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "na any injury or other traumatic event, If Item one. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Carrier Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorain E. Robinson Luther L. Johnson Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8903 Allenswood Road, Randallstown, MD 21133 Zelda Johnson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-28-09 Metro Crematory Baltimore, MD 22. Name and Address of Facility Wile Funcial Forme P.A. of Palto. Co. 21. Sign here of Funeral Service Licensee 9200 LibertyRoad, Randallstown, MD 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thousing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 Tes 2 No 2 ER/Outpatient 3 DOA 5 AResidence 6 □ Other (Specify) 1 Inpatient Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation nours after death.
neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO04293

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(W/Os

31. Date filed (Month, Day, Year)

22 South

32. Registrar's Signature

09-04003 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **Dudley Willis Jones** 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical Examine Dudley Willis May 20, 2009 Jones 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Union Bridge 4 East Broadway Apt. 2 5. Social Security Number If Under 1 Year | If Under 24Hrs. **Funeral** Age (In yrs. last birthday Months Days Hours Min Director 1 XM 2 F 67 218-38-4148 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location any 28a-f show items 23a or 28a-f shoust be notified at once. Carroll s I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f she MD Union Bridge Director 10e. Street and Number 10f. Zip Code 4 E. Broadway 21791 Apt. Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or Noor other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 1 X Yes If Yes, Give Year 1963-65 Yes 2 X No specify Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. 12 railroad car restoration 17. Father's Name (First, Middle, Last) Be William Abraham Jones Pages 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) William H. Jones/brother Daisy Dr. Taneytown. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) VA 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Cem. /3/2009 Donation 5 Other Specify Signature of Funeral Service Licensee 22. Name and Address of Facility Broadway **Physician** failure. List only one cause on each line /Medical Upper Gastrointestinal Hemorrhage Immediate Cause (Final disease **kaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit sician/Medical attending physician a UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) No 9 Unknown Yes 2 q Unknown icate has been signed by the page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Cirrhosis of liver, Hypertensive cardiovascular disease Completed 24a, Was an certificate Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other<sub>4</sub> Nursing Home 5 To Inpatient ER/Outpatient 3 this 1 Yes No 27. Manner of Death 28b. Time of Injury

8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Aug. 18, 1941 Maryland 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry railroad 18. Mother's Name (First, Middle, Maiden Surname) Rosie Lee Willis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Owings Mills, MD Hartzler Funeral Home Union Bridge. MDPart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Between Onset and Death of Vital Records, P.O. Box 68760, 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? Probably 4 🗸 Unknown Yes 2 No 3 24b. Were autopsy findings available prior to completion of cause of performed? death? Yes No No Hospital or Attending Physician: Residence 6 V Other: Scene 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year After Certification: 1 🗸 Natural Division Yes 2 No Pending 24 hours after death the Accident 2 Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E May 21, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month, Day, Year, State Registra

0817 hrs

c. County of Death

Carroll

DHMH 17 Rev 1/2001 **OCME 2006** 

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 25. 2009 8:00 a. M Kozub Jacques 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery 6401 Kenhowe Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Year) 1 <del>∏</del> M 2 □ F 25, 1932 France 324**-**26-6729 Jan. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 XNo MD Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20817 6401 Kenhowe Drive 12. Was Decedent Ever in U.S.

Armed Forces?

1 XYes 2 □ No 1951—
If Yes, Give
Year or Dates: 1961 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify: White Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) World Bank Economist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucienne Gamain Romain Kozub 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6401 Kenhowe Dr. Bethesda, Maryland 20817 Marcia Hicks Kozub (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 27, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 2009 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Ser. 21. Signature of Funeral 933 Gist Ave. Silver Spring, MD 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sudden disease or condition resulting in death) Cardiomyopathy Due to (or as a consequence of): Years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Years Chronic Lung Disease Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans P.O. Box 68760, attending p signed by the a Division of Vital Records, certificate has been s rector, page 2 should After after death. 1 24 hours after deg ie Funeral Directo bletely filled in by th within 2

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

ral", or items 23a or 28a-f sh Examiner must be notified

"natural"

7 Is marked other traumatic event,

permit. Pages 1 and 2 should be filled. Department of Health and Mental Hygin Important: If item 27 is marked any hilury or other the page.

**Physician** 

/Medical

Director

Funeral

Completed by

Be

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Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

funeral director,

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

Vassallo, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

30. Name ar

(Check only

5454 Wisconsin Ave. Suite 925, Chevy Chase, MD 20815 32 Registrar's Signature

ress of person who completed cause of death (Item 23a) (Type, Print)

parker

**ORIGINAL** 

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0033844

29d. Date signed (Month, Day, Year)

May 26, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. Month Day. WEST HOSPITAL TIMORE SNIEK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 217-50-29 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Baltimor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Woo or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Blac Completed by 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12)

13 Years

17. Father's Name (First, Middle, Last) College (1-4or 5+) altimore City Public Schor Educator years 5+ 18. Mother's Name (First, Middle, Maiden Be and Mental h u) illiam heeks livia ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 1336 Pentridge Rd Item 27 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. -09 Woodlawn, My 5-28 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee iberty Rd. Randalstom 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a cons-Examine physician and stransit the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 ☐ Onknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death?

1 \[ \text{Yes} \quad 2 \[ \text{No} \] 24a. Was an performe certificete 1 Yes 2 No director To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Nes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 Suicide 4 Homicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire lilled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 2000 30. Name and address of person who completed cause of death (Item 83a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 23 2007 4c. County of Death oe Inomas /Medical 4a. Facility Name (If not institution, give street and number) Examiner 28321 Crisfield Marion Road Marion Station Somerset 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral**  Birthplace (State or Foreign Country) Days Hours 1 ☑ M 2 □ F 76 Director 425-66-1536 4/28/1933 Mississippi Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f sh notified 1 XYes 2 No Director Somerset Marion Station 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 28321 Crisfield Marion Road 21838 U.S.A Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ★Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Military Police 12 Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dewey Lloyd Anna Millwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Betty Lloyd/ Wife 28321 Crisfield Marion Rd., Marion Station, MD 21838 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 4 ☑ Donation 5 ☐ Other (Specify) 5/26/2009 | Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service License 7522 Connelley Dr., Ste.P, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastutic differentiated 2 month Doorly disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the bunal-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2.No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a Macertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

30. Name and address of

31. Date filed (Month, Day,

cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

VAMC 10 N. Greene St. Baltimore, MD 21201

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23 Year 6 PM ve ste 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 503 JJ12 18 Himore 8. Date of Birth (Month, Day, If Under 24 Hrs. T 9. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number Age (In yrs. last birthday) Hours 1 X M 2 □ F 239-22-5530 90 - 20 -Morth Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 3a 1 XYes 2 □ No Hmore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 U.S. A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: ( L 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Dack 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 nee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lamb Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mesa E. Ivy a 150k; 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 30 2009 Burgaw, n. Carolina 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mc Culler St. Ba Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) House MYOCARDIN WENDETTOR Due to (or as a consequence of): YEHA HYLLE WSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offs HYALR CHOLES RIPOLEM Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

1 ☐ Yes 2 ☐ No

BATILINOM

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

BLUD

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

that the death certificate be executed sician and burial-tran physician the burial P.O. Box 68760, attending as asn for signed by the a Records, has Vital Hospital or Attending Physician: of

director, this After thi

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

2 Accident

4 Homicide

3 Suicide

29a. Certifier

6 ☐ Could not be

ed other than "natural", or items 23a or 28a-f show event, the Medical Evanings must be rediffed at

is marked other than

permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any Injury or other trau

**Physician** 

/Medical

Examiner

1 and 2 should be filed within Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Medical

State

Registrar

A wingson and 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

32. Registrar's Signature

and manner stated.

001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

park

withourson

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1	For State Registrar	ricase	State of			d / Depa		t of H	lealth	and M	_	lygi		2009	16881
Physician		1. Decedent's Name (	(First, Middle, La	·	in (	Jr.						2. Date of Month May			200 <sup>Ye ar</sup>	3. Time of Death 3:37p M
/Medical Examiner		4a. Facility Name (If n	not institution, giv Hospice	e street and nu Dove Ho	ımber)			4b. City, West	mins	ster				4c. Co	unty of Death arroll	
Funeral Director		5. Social Security Nur  216-12-09  Usual Residence of D	55	Sex X M 2□ F	7. Age	e (In yrs. la	rst birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date of (Month, July)	Birth Day,	<sup>Year)</sup> 192	9. Birth Cou	place (State or Foreign ntry) VA
Maryland -f show	T	10a. State	Carroll				Town or Loo						-			10d. Inside City Limits 1 ∐Yes 2 🛣 No
ther death with the Marylan ritems 23a or 28a-f show incr must be notified at Founeral Director	-	10e. Street and Numb		ad		<u>.                                    </u>		10f. Zip					109		n of What Cou	ntry?
be filed within 72 hours after death with the Maryland to Hygiene.  to diret than "natural", or items 23a or 28a-f show event, the it adject Everning must be notified at Be Completed by Funeral Director	١.	11. Marital Status 1 □ Never Married 3 ▼Widowed 4	d 2 Married	12. Was Dec Armed For 1 X Yes If Yes, G Year or D	orces? 2  N ive Dates:	Everin U.S	I	□Yes 2	. No	Specify		ecify Yes or Rican, etc.)		Sp	Race - Ameri Black, White, pecify: wh	etc. ite
permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or i any injury or other traumatic event, I'm I solice! Eventione.  To Be Completed by F		(Specify	5. Decedent's Edy only highest graduary (0-12)	ducation ade completed) College ( 4		+)		lent's Usua kind of wor 20 NOT us :lerk	l Occupa k done d e retired	ation furing mo	st of workii	ng	- 1		of Business/Ir	counting
Mental Hy arked oth atic event		17. Father's Name (Fi			Sr	•					Barne	(First, Mid ett	dle, Ma	aiden Sui	rname)	
and 2 sho lealth and m 27 is m her traum		19a. Informant's Nam Deborah W	lalters		er)	1	20 Ch	ape1	Vie	w Dr	, Re	inhol	ds,	PA :		
Pages 1 tment of P tant: If ite jury or ot		20a. Method of Dispo 1 ☐ Burial 2 ☐ 4 ☐ Donation 5	Cremation 3 ☐ Other (Specif	y)	State	20b. Pl	ace of Dispo emetery, cren Count	y Cre	emat:	ion	5-26		S	ykes	tion - City or T ville,	MD
permit Depar Impor any in once.			Hardra	sperb	ىرور	*	Р.	0. Bo	x 19	95 S <sub>3</sub>	kesv	ille,	MD	217		Chape1
Physician /Medical Examiner		23a. Part 1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	inal	a	1	the death ne. A consequ	16	er the mode	e of dyin	g, such a	s cardiac c	or respirator	ry arres	st,		Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medi		IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ I 9 ☐ Unknown	onths?		birth gnant at	of pregnar 2  ☐ Fetal t time of de	death 3□	Ectopic po		у			_	230	d. Date of deliving Month	very Day Year
law requires that the das been signed by the 2 should be detached	•	Part II. Other signific	ant conditions	contributing to c	leath bu	ut not resu	lting in the ur	nderlying ca	use give	en in Part	1.			acco use		the cause of death?
: The law requir												24a. W ai p 1 □ Ye	utopsy erform		prior to o death?	opsy findings available ompletion of cause of
Physician this certifi al director.		25. Was case referred examiner? 1 ☐ Yes 2 ☐ No.			<u> </u>		ER/Outpatien			er: 4 🗆 N		n <i>(Check or</i> me 5□ F		) nce 6 🖺	Other (Spec	in DOVE HOUS
tal or Attending Presenting and Director: Affer led in by the funeration:		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	e 28e. Place	nth, Day	y, Year)	28b. Time of Injury me, farm, stre	М		yat ⟨? Yes 2.[	]No	28d. Descri 28f. Locatio City or	on (Stre	eet and N		ral Route Number,
he Hospital in 24 hours a he Funeral I ipletely filled		29a. Certifier 1 (Check only 2 one) 2	☐ Certifying PI	nysician: To the niner: On the and mar	basis o	f examinat	vledge, death ion and/or in	occurred vestigation	at the tir , in my o	me, date a	and place, eath occurr	and due to red at the tir	the ca	use(s) ar te and pl	nd manner as ace, and due	stated. to the cause(s)
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5 V		30. Name and addres	. 5	EK	5	55 0	7.CE	Print)	RS	ī	W	ETM	111	STE	er M	० २११५२
State Registrar		31. Date filed (Month,		Zenova 32.	Registra	ar's Signat	ark)									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examiner physician at the burialcertificate d in by the within 24 hours aft

To the Funeral Di

completely filled in

Physician

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

Completed by

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.

- 1	21. Signature of Funeral Service Licen	see) .	Sc. Name and Address of Facility Sc	himunek Fu	meral Ho	me
İ	Defaule K	Juker	9705 Belair Rd	. Nottingh	am. Md.	21236
	shock, or heart failure. List only	olications that caused the death. Do no one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of)	hat intarction			Inour
Pydilligi	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of)  c	ydiscose			
The second secon	(	d				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
	Part II. Other significant conditions of	ontributing to death but not resulting in the	he underlying cause given in Part I.			the cause of death?
				24a. Was an autopsy performed? 1 □ Yes 2 ☑	death?	topsy findings available completion of cause of
J	25. Was case referred to medical examiner?			h (Check only one)		
ļ	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outp	patient 3 DOA Other: 4 Nursing He	ome 5 Residence	6 ☐ Other (Spec	cify)
	27. Man er of Death  1 Natural 5 Pending 2 Accident investigation		nne of ury 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how inj		==11===
	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	29a. Certifier 1	ysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the time, date and place /or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	29b. Signature and title of certifler	Kenle	29c. License number	29d. [	Date signed (Month)	Day, Year)
- 1						

Registrar DHMH 17 Rev 1/2001

State

ed (Month, Day, Year,

MAY 27 2009

2.900 Franklin Square Dr. Baltimorz, MD 21237
32. Registrar's Signature

ank Moroschok	State of Maryland / Department of 1-For State Certificate of		ne Reg. No. 2009 L63.{
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Da	ate of Death 3. Time of Death
ledical Examine		Ma  4b. City, Town, or Location of Death	onth Day Year 1100 hrs 4c. County of Death
	Upper Chesapeake Medical Center	Bel Air	Harford
Funeral Director	5. Social Security Number 216-66-8282 6. Sex 17. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)		Pate of Birth MM/DD/YYYY) 9. Birthplace (State or Foreign MD Country)
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat	ion	10d. Inside City Limits
ž .	MD Harford Bel Air		1 Yes 2 No
j in in in in in in in in in in in in in		10f. Zip Code 21015	10g. Citizen of What Country?
or items 23	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was If Y 14. Married Porces?	is Decedent of Hispanic Origin? (Specify es, specify Cuban, Mexican, Puerto Ricar	
s after de ral", or almer mu	Widowed 4 Divorced in res, diversel	Yes 2. No specify:	Specify:
hours a	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	nt's Usual Occupation (Give kind of work d lost of working life. DO NOT use retired)	done 16b. Kind of Business/Industry  Labor
vithin 72 hours ene. er than "natur Medical Exam	12 Tile	Setter	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	17. Father's Name (First, Middle, Last)	18.Mother's Name (Firs	t, Middle, Maiden Surname)
2121 ould be fil d Mental b s marked fic event,	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailin	g Address (Street and Number or Rural	Route Number, City or Town, State, Zip Code)
MD  1d 2 sho  1d 1d sho  1d 2 sho  1	Sandra Moroschok/Wire 1700		el Air, MD. 21015
Baltimore, MD 21215-005 permit. Pages I and 2 should be filled with Department of Health and Arenal Hygiene Important: If item 27 is marked other Injury or other transmatic event, the Med To Re Comm	1 Burial 2 Cremation 3 Removal from State crematory or of		4/,   Rollesvillo MD
altim mit. Pa partmer portau	21_Signature of Funeral Service Licensee \\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	Name and Address of Facilit CAFA/	Stephen D.Lohrmann P.A.
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	3717 Green Pastu	
Physician /Medical	failure. List only one cause on each line.		Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	cotic inconfederal	and codding and
	Sequentially list conditions, b		
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated  C. Due to (or as a consequence of):		
cuted	events resulting in death) Last  d.  [X] UNPENDED  AMENDED  AMENDED  23a,27,28a-f,	ME ~902 6/12/0	0 77
60,  the be executed  the bysician and  bysician and  churial - transit		perME, go92 0/12/09	23d. Date of delivery
3876 rtificate ling phy as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic pregnancy	Month Day Year
Box 68760, he death certificate be to the attending physic hed for use as the bur	23b. Was decedent pregnant in the past 12 months?  1	other (Specify)	
Records, P.O. Box 6876  The law requires that the death certificat cate has been signed by the attending phage 2 should be detached for use as the		underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 V Unknown
cords, P.O. law requires that the has been signed by the 2 should be detached.			24a. Was an 24b. Were autopsy findings available
of Vital Records, ng Physician: The law required the third this certificate has been someral director, page 2 should the third			autopsy prior to completion of cause of death?
		26.Place of Death (Check only	
Vita hysicia this cer	25. was case referred to medical examiner?  1		
n of ding Ph		1 Yes 2X No. 111	d. Describe how injury occurred ${f nk}$
Division pital or Attendit ours after death. reral Director: A	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc. 28f	E. Location (Street and Number or Rural Route Number, City or Town State) 1706 Hawthorne Ctel Alr, MD
Divis	4 Homicide determined (Specify) FOUTIG: PEST		
	A Cartifler 1 Certifying Physician: To the best of my knowledge, death occ (Check only one)  7 Medical Examiner: On the basis of examination and/or investig	urred at the time, date and place, and due ation, in my opinion, death occurred at the	e to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
To with	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	him his, was	O.C.M.E.	May 24, 2009
m	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 21201	
Sta	e 31. Date filed (Month, Day, Year) 32. Registrar's Signature	parke	
Registr	MAY 27 2009 Senera B. A	F	

			For	State of M	/larylan		rtment of H		Mental Hyg	jiene	000	10001
			State Registrar			Cer	tificate of L	Death		teg. No. 🚄 🕻	107	10004
I	Physicia /Medic		1. Decedent's Name (First, Middle, MICHAEL	Lasti	Mil	SNONE	Jr		2. Date of Deal	Day 19	Year g	3. Time of Death
	Examin		4a. Facility Name (If not institution,				•	Location of Death		4c. County		11
mary of a			Anne Arundel Med 5. Social Security Number 6			last birthday)	Annapol:	LS If Under 24 Hrs.	8. Date of Birth	Anne		I⊖ 1 lace (State or Foreign
	Funeral Director		213-70-6696	1 M 2□F	51	Yrs.	Months Days	Hours Min.	(Month, Day 12/24/	(Year)	Cour	York
	D		Usual Residence of Decedent								14	0d. Inside City Limits
	arylar show	r	10a. State 10b. County	3 - 3		y, Town or Loc	cation				1	1 ☐Yes 2 ☑ No
	he Mi	Director	MD Anne Ar	undel	Anna	polis	10f. Zip Code			10g. Citizen of	What Cour	
	with Ba or		19-A Lafayette	Avenue			21401			U.S.A		,
	death	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Ra	ce - Americ	
98	flied within 72 hours after death with the Maryland Hygiene. Hygiene. than "natural" or items 23a or 28a-f show ant, the Medical Examination roust be notified.		1 ☐ Never Married 2X Marrie	d Armed Forces 1 ☐ Yes 2 ∑ If Yes, Give			Yes 2⊠No	Specify:	o nican, etc.)	1	ck, White, fy: <b>Whit</b>	
Ö	hours 'ural'',	ed by	3 Widowed 4 Divorced	Year or Dates	S: 	16a Decec	lent's Usual Occup	ation		16b. Kind of B		
7	in 72 n "nal	Completed	15. Decedent's (Specify only highest	grade completed)		(Give life. L	kind of work done of NOT use retired	during most of work (1)	king	TOD. TAITO OF E	000000	300.7
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or	r 5+)	Credi	t Manage	r		Furnit	ure	
Maryland 21215-0036	should be filed vand Mental Hygies marked other to	Be C	17. Father's Name (First, Middle, La					18. Mother's Nam				
yla	ould b	P	Michael Louis	Mignone				Loretta	Rowan	Buccha	_	
Mar	12 sh th and 7 is m traum		19a. Informant's Name/Relationshi			1	g Address (Street Lafayett			-		Code)
ē,	1 and Health tem 27 other to		Ellen Mignone/ V	AITE	20b. F		sition (Name of natory or other place		Date	20c. Location		wn, State
ltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanimation with be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe		e i		ts Registry	i - 10.	2/2009	Hanover	, Mai	ryland
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Li		1		. Name and Addre			fts Rec	jistry	7
m	B a E G		1 50150	1)		75	22 Conne	lley Dr.	Ste.P,	Hanover	, MD	21076
			23a. Part 1. Enter the disease, or c shock, or heart failure. List or					-				Approximate Interval Between Onset and Death
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nd.	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence of):	VREN A	romi o	linkole	san .		40 pm
		er	Sequentially list conditions if any, leading to immediate	Due to (or a	as a conseq							Ja
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с.								
Ő,	ate be executed ohysician and the burial-transit		resulting in death) Last	Due to (or a	as a conseq	uence of):						
8760,	cate be executed physician and the burial-transit	dical	`	d								
9 ×	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcom	ne of pregna	ancy				23d D	ate of deliv	erv
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S,	ss tha	by P	Part II. Other significent condition	s contributing to death	but not res	ulting in the ur	nderlying cause giv	en in Part I.				he cause of death?
ord	w require been signal								1 L Y	′es 2. No	3∐ Pro	bably 4 Unknown
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a	n: The ficate r, pag								1 □ Yes	2 2 No	1 ☐ Yes	2 🗆 No
<u>=</u>	s certificate has triector, page 2 s	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	ationt 2 🗆	ER/Outpatier	oth	or	ath <i>(Check onl. o.</i> Iome 5 ☐ Resid		that /Casa	6.0
o	g Phys er this eral dir	n: T	27. Manner of Death	28a. Date of Ir	njury	28b. Time of			28d. Describe h			
io	ttending Figers. tor: After the funers	atio	1 Natural 5 Pending 2 Accident investiga	ution	Day, Year)	Injury		Yes 2 □ No				
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Certification: To	3 ☐ Suicide 6 ☐ Could no determin	ed 28e. Place of i building,	injury - At he etc. (Specia	ome, farm, str fy)	eet, factory, office		28f. Location (S City or Tox		ber or Rur	al Route Number,
۵	pital c		29a. Certifier 1 Certifying	Physician: To the be	et of my kno	wledge deat	o occurred at the ti	me date and place	and due to the	cause(s) and r	manner as	stated
	e Hospital 124 hours a e Funeral letely filled	edical	(Check only one)	complement On the basis	a of our mine	tion and/or in	ventination in my	minion donth again	urrod at the time	data and place	and due	to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	2	1		29c. Licens	e number		29d. Date sign	ed (Month	Day, Year)
			HM I I	Ne	The L	7	D	21438		Mon	192	009
7	V		30. Name and address of person w	ho completed cause o	of death (Iter	n 23a) (Type,	29c. Licens D Print)  ENSE H 6	41 10 A	NAPULI	MOZI	¥01	
l			31. Date filed (Month, Day, Year)	JENIYT M	strar's Sinns	UEFE	N3E 1116	1 may 11		* -, -,	. 0/	
	Sta Registr		MAY 2.72	000		1. ba	Kal					

09-04096 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jennifer Mocere State of Maryland / Department of Health and Mental Hygiene 2009 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day May 22, 2009 2149 hrs **Medical Examiner** Jennifer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Maryland Director 219-11-0177 Days Hours May 18,1984 1 M 2 XF 25 Usual Residence of Deceden 10d. Inside City Limits 4uv 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No "natural", or items 23a or 28a-f sho Examiner must be notified at once, Maryland Baltimore Dundalk Pages 1 and 2 should be filted within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8159 Grayhaven Road 21 222 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 X No Yes Specify: White 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 12 years Professional House Cleaner Cleaning 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Thomas Leonard Mocere Debra Jean Lang or other tranmatic event, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) 7819 Eastdale Road, Dundalk, Maryland 21224 Thomas L. Mocere Jr. Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State May 28, Oak Lawn Cemetery Dundalk, Maryland 2009 Other Specify 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, 7110 Sollers Point Road, Dundalk, Signature of Funeral Service License Dundalk, P.A. Dundalk, Maryland 21222 Part I. Enter the disease or complications that caused the death. 🔯 not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Hanging Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Fetal death past 12 months' Pregnant at time of death 1 Yes 2 No 9 ✔ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has death? performed? ✓ Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: Subiect hanged self FOUND: Natural Pending Yes 2 V No the May 22, 2009 2030 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 1741 Merritt Blvd, Dundalk, MD determined (Specify) Jail/Penal To the Funeral Homicide 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 23, 2009 30. Name and address of person who completed cause of death (Item 23a) **OCME** 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD. Deputy Chief Medical Examiner 31. Date filed (Month, Day, Vear) -State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** NICICIF /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medica 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Year 1 M 2 □ F Months Days Hours Min. ntry) WV 9-16-1938 236-62-0137 70 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ital Medical Expriser must be a cofficed any Injury or other traumatic event, Ital Medical Expriser must be a cofficed and once. Baltimore City 1 XYes 2 □ No Director MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21224 USA 4322 E. Lombard Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: ☐ ☐ ☐ ☐ ☐ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Hauling Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary McGrady ٥ Joseph McGrady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys McGrady - Wife 4322 E. Lombard St., Baltimore, MD21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Oak Lawn Cemetery 5-29-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral S 21222 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** wais disease or condition resulting in death) /Medical Examiner activieus Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 ☐ Unknown 9 Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1∐ Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ After thi funeral o 27. Manner of Death Date of Injury (Month, Day, Year) 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: A d in by the f 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical El Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name at

d address of pers

27

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltinov

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2307

09-04080 Darla Mcie Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 16887 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 22, 2009 Medical Examiner 1304 hrs Darla Nannette McIe 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death Route 550 @ Hoffman Seachrist Road Walkersville-**Frederick** Woodsboro If Under 1 Year | If Under 24Hrs. | 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** West Months Days Hours Min. Director Country) July 25,1961 232-02-2731 M 2X F 47 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County Yes 2 X No or 28a-f show Walkersville MD Frederick with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21793 U.S.A. 10534 Daysville Rd. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. hours after death 1 Never Married 2 Married 2 X No Yes 4 X Divorced If Yes, Give Year Yes 2 X No specify: Widowed Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 hant of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) than MD 21215-0036 kitchen worker restaurant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Glenn Starkey Jr. Loula Ann Cochran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is David Blank - fiance 10534 Daysville Rd., Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore. crematory or other place' 1 X Burial 2 Cremation 3 tment ( mportant: Chapel 5/28/2009 nr. Libertytown, Cemetery Donation 5 Other Specify ign, ture of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home 404 S. Main St., Woodsboro, MD 21798 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death). Last Due to (or as a consequence of): that the death certificate be executed Physician/Medical 4b & 28t, perME, g893 6/8/09 TT UNPENDED X AMENDED attending physician for use as the burial Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year Live birth Fetal death 3 Ectopic pregnancy past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 V Unknown The law requires Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has b performed? death? certificate 1 🗸 Yes ✓ Yes 2 No To the Hospital or Attending Physician: within 24 hours. fler death.

To the Funeral Director: After this certificompletely filled in by the funeral director; 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital æ examiner? Hospital: 1 DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes ဥ 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? Certification: May 22, 2009 driver of vehicle involved in motor vehicle Natural 1253 hrs Yes 2 V No Pending accident 2 🗸 Accident Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) **WOODS DOTO**, **MD**Route 550 @ Hoffman Seachrist Road, Welkerswile, A 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined (Specify) Interstate/Express Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. May 23, 2009 M. 30. Name and address of person who completed take of death Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day 7, 2009 32. Registrar's agnature arke Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #18 per Fh G891 5/27/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>009</u> Month **Physician** LOUIS MALOFF 23, 3:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WESTMINSTER CARROLL DOVE HOUSE Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Funeral **№** М 2□ F Months Days Hours Min. 047057 1930 79 MD 217-24-9338 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 28a-f show ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at MD CARROLL WESTMINSTER 1 □Yes 2 No Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1602 CARRIAGE HILL DRIVE 21157 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BUS DRIVER BOARD OF EDUCATION 18. Mother's Name (First, Middle, Maiden Surname)

RACHAEL FELDMAN 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be finent of Health and Mental **JOSEPH** MALOFF 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any Injury or other trat once. EMMA JEAN MALOFF / WIFE 1602 CARRIAGE HILL DRIVE WESTMINSTER, MD 21157 20b. Place of Disposition (Name of OHEC Property Community of OHEC Property Community of OHEC Property Community of OHEC Property Community of OHEC Property Community of OHEC Property Community of OHEC Property Community of OHEC Property Community of OHEC Property Community of OHEC Property Community of OHEC Property Community of OHEC Property Community of OHEC Property Community of Community of OHEC Property Community of Communit 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 05/24/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., May 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on path line. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. physician Physician/Medical the anding pluse as t IF FEMALE: for use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a o 9 Unknown 9 Unknown ئم 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe certificate 2 **N**0 Division of Vital 1 ☐ Yes 2 🗷 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Yes 2₫No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attenct within 24 hours after death To the Funeral Director: the 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifie 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check on one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) lece 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FCAULO KWITTER 555 S. CENTER 5.7 WELF HINSTER MO 2115 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 27 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 25, 2009 1:30  $p_M$ **Physician** Tarakad Nagalakshmy May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Manor Care Silver Spring Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 12/8/1934 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours India 218-31-8949 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Inours auter useau with the Invertigation of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middel Event for constitution once. MD Montgomery Burtonsville 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 3402 Ardsley Court 20866 India Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.Asian Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tarakad Krishna-Iye r A.S. Lakshmy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lalitha Swaminathan 3402 Ardsley Ct. Burtonsville, MD 20866 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Chesapeake Crematory 5/26/2009 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rapp Funeral & Cremation Ser. h 933 Gist Ave. Silver Spring, MD 20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final LV Physician ACUTE INFARCTION MYDEARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CONGESTVE HEART Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day ☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
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neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical 29a, Certifier ī Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D-17874 5-25-2009 5

DHMH 17 Rev 1/2001

State Registrar COTTAGE CITY,

380

MD 20722

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3717

Registrar's Signature

S.M. NAYAR

31. Date filed (Menth, Day, Year)

		1 - State Registrar		Cei	rtificate of			Reg. No. 2	009	1689
nysicia	an	1. Decedent's Name (First, Middle, La George Newman	Numsen				2. Date of De Month	ath Day	Year	3. Time of Death
/ledic amin		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of Death	ICCV10	4c. Co.	unty of Death	
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ral tor		,	Sex 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan 27	th iy, Year)	9. Birth Cou	place (State or Forei
		Usual Residence of Decedent	70	115.		1	Jan 2/	1931		MD
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	ecto			Dykeby.		· · · · · · · · · · · · · · · · · · ·				1∭Yes 2□N
	١	10e. Street and Number 7200 Third Avenu	ie C-40		10f. Zip Code 21784	<u>'</u>		US. Citizen	of What Cou <b>A</b>	intry?
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	y Fu	1 Never Married 2 Married	Armed Forces? 1 □Yes 2 □ No If Yes, Give	7	i Yes, specity Cub 1 □ Yes 2 □ <b>X</b> No	an, mexican, Puerto F  Specify:	tican, etc.)		Black, White, <sub>ec<i>ify:</i> whi</sub>	
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	Be	17. Father's Name (First, Middle, Last	1)			18. Mother's Name Margaret	(First, Middle,	Maiden Sur	name)	
	မှ	John Numsen				_				
		19a. Informant's Name/Relationship Mrs. Virginia Num				and Number or Rura. e., C-40,				
ł		20a. Method of Disposition			sition (Name of natory or other place		ate		on - City or T	
		1 ☐ Burial 2 ☐ X remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Themoval nom State   A 1	cemetery, cren 11 Count	natory or other plac y Cremat:	ion   5-26-	09	Sykes	ville,	MD
i		21. Signature of Funeral Service Lice	nsee	22	. Name and Addre	ess of Facility Hai	ght Fu	neral	Home 8	Chapel
3		▶ Parge Haigh	Herbert	P	.O. Box	195 Sykesv	ille,	MD 217	84	4.00
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.		2	ng, such as cardiac o	r respiratory a	rrest,		Approximate interval Between Onset and Death
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		resulting in death) Last	Due to (or as a cons	sequence of):						
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- 1	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-		_			23d.	. Date of deli	verv
-	sicia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnand Other (specify) _	<del></del>			Month	Day Year
	~	9 Unknown					1	. !		
	듄	Part II. Other significant conditions	contributing to death but not i	resulting in the ur	nderlying cause giv	en in Part I.				the cause of death?
		1 DPD N MPN	AD THLY	(3)	FACE					
		CORONARY	ARTHRY	Dr.S.	EASE		04: 144:		4b. were au	opsy findings availab ompletion of cause o
		CORONARY	ARTHLY	<u>Dis</u>	EASE		24a. Was autop perfo	rmed?	death?	- 00
	Completed by	CORO NARY  25. Was case referred to medical	ARTHLY	1925	EASE	26 Place of Dooth	autop perfo 1 □ Yes	rmed? 2 ☐ No	prior to c death? 1 □Yes	2 🗆 No
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Howard G. Oliver III 200'9 7:30a 22 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Svkesville 806 Dixon Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1**1** M 2□ F Months Days Hours 55 207-44-2546 N.J 1953 Oct 24 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Martical Examination to the promotive it was by matthing at Sykesville MD Carroll 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? USA 21784 806 Dixon Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □ Yes 2 □XNo Specify: white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) alcohol beverage Elementary/Secondary (0-12) College (1-4or 5+) sales manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pat Keough-Dwyer Howard Oliver II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 Dixon Ave., Sykesville, MD 21784 19a. Informant's Name/Relationship (Type. Print) Francine S. Oliver (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation | 5-24-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Paray Sparight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown momar Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an nas autopsy performe certificate 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Yes 2☐No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Records, P.O. Box 68760, Division of Vital d i...
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State Registrar

Medic

29b. Signature and titl

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and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

			For State	State of Ma	ıryland	•	artmen rtificat			and M		gien Reg. N	e 2 N	09	16893	2
			Registrar  1. Decedent's Name (First, Middle, La:	st)			·····	0 0 1 2			2. Date of De	ath		1.	3. Time of Death	
	Physici /Medio		Eladi	io Pi	inedo						May 20	0, 2	009	Year	12:30 avm	n
4	Examin	er	4a. Facility Name (If not institution, giv	,		_			Location o	of Death			. County			
_			Shady Groave Adv  5. Social Security Number 6. S			ast birthday)	Roc]	kvil 1 Year	le If Under:	24 Hrs. 1	8. Date of Bir	rth	Mont		y lace (State or Foreign	
ı	Funeral Director		219-49-9364	TVM 2DE	30	Yrs.	Months	Days	Hours	Min	Jan 8	y, Year 19	29	Peru	itry)	_
	yland now		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation							1	0d. Inside City Limits	_
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	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 🔀 Married	12. Was Decedent E Armed Forces? 1 \( \text{Yes} \) 2 \( \text{V} \)		. 13.	f Yes, spec	ent of Hi			cify Yes or No Rican, etc.)	)-		k, White,	an Indian, etc.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at once.	5	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			l∭XYes 2	2 □ No	Specify:	Per	uvian		Specify:	· V	Vhite	
<u>5</u>	"natu	lete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	rk done o	lurina mosi	t of workir	ng	16b. I	Kind of Bu	siness/Ind	dustry	
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		3	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each lin	the death. e.	. Do not ent	er the mod	e of dyin	g, such as	cardiac c	r respiratory a	arrest,			Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Sepsis Due to (or as a	conseque	ence of):								-		_
and the	Examiner		Comment in the line on the inner	b. Urinar		,	fecti	on								7
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	Due to (or as a												
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9	rtificate ng phys	Medi	IF FEMALE:											:		nits No
Box	death certific e attending p d for use as	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗆 Fetal	death 3	Ectopic p		/				23d. Date Mor	e of deliventh	ery Day Year	
o.	that the dened by the stacked f	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5 L	Other (sp	ecify)								
ი, თ.	s that gned b	by Pł	Part II. Other significant conditions of	contributing to death bu	t not resul	lting in the u	nderlying ca	ause give	en in Part I.		23e. Did	tobacco	use contr	ibute to the	ne cause of death?	
ord	w requires to be signal and be signal	ted t	<u>Multiple Myelom</u>	a							1 🗆	Yes 2	2 ☑ No	3 Prob	pably 4 ☐ Unknown	ı
Part II. Other significant conditions contributing to death but not resulting in the underlying cause  Multiple Myeloma  Part II. Other significant conditions contributing to death but not resulting in the underlying cause  Multiple Myeloma							24a.				Was an autopsy find prior to completion			psy findings available mpletion of cause of	t	
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o c	ding Phys h. After this funeral dir	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	v  :	28b. Time of Injury		8c. Injury Work			28d. Describe				у)	-
200	endin sath. or: Af he fur	atio	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	, rear)	injury	М		r Yes 2 🔲 I	No						
Division of Vital Records,	al or Attending Physician: s after death. I Director: After this certific, ed in by the funeral director, p	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						2	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
_	Hospital or 24 hours afte Funeral Dir stely filled in		29a. Certifier 1KMCertifying Ph	nysician: To the best o	f my know	vledge, deat	n occurred	at the tin	ne, date ar	nd place,	and due to the	cause	(s) and ma	anner as s	stated.	_
	To the Hospital within 24 hours a To the Funeral Completely filled	ledical	one)	niner: On the basis of and manner sta		ion and/or in				ath occurr	ed at the time					_
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-			Brian Carpenter	V .	01 M	edical	Cent	ter 1	Dr. R	ockv:	ille,	1D 2	0850			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 2009 Herman Ma /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Raltimore
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Bayview Medical Ohns Hopkins
ocial Security Number 6. If Under 1 Year Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** Months 1₽M 20 F Davs 82 Director 437-28-7747 22, 1927 Louisiana Jan. Usual Residence of Decedent 10d. Inside City Limits 10a State 10h Count 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examilian is as the notified at 1 ☐ Yes 2 📆 No Director Maryland Harford Edgewood 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2510 Hanson Road 21040 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 2 3 Widowed 4 Divorced Year or Dates White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ordnance Instructor U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Henry C. Procell Annie (nmn) Leone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 Health Norma King Procell L-Wife 2510 Hanson Road, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 DyBuria 2 □ C Other (Spec Bel Air Memorial Gdn | 5-29-09 Bel Air, Maryland tion 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Sign turn of Fun 1317 Cokesbury Road, Abingdon, Maryland 21009 art i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fhock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiac disease or condition resulting in death) 5 minutes /Medical Due to (or as a consequence of) Examiner Difficile infection Clostridium if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit SCPS15 and Due to (or as a consequence of) Box 68760 physician certificate be Physician/Medical the attending IF FEMALE: Ise yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No P.O. the 9 Unknown 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Was a.. autopsy performed? Yes 2 No 24a. Was an certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day, Year) 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

SHAKER 31. Date filed (Month, Day, "Year)

29b. Signature and title of certifier

M.D. 30. Name address of person who completed cause of death (Item 23a) (Type, Print) 5200

29d. Date signed (Month, Day, Year)

D006781

castern Ave Balpimore MD: 2122

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9:54 A M May 25. Juan Jose Pabon' 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Stella Maris Hospice Baltimore Timonium If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) 10 MM 2□ F Months Days Hours Min. 65 11/09/1943 109-32-7946 Puerto Rico Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 1 ☐ Yes 2 No Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1481 Pangbourne Way 21076 Was Decedent Ever in U.S. Armed Forces? 1 BYes 2 □ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Folces. 1 Byes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Nes 2 No Specify: Puerto Rican Specify: 3 Widowed 4 Divorced Hispanic 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Residential Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk Unk Unk Unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zoraida Powell/Daughter 1481 Pangbourne Way Hanover, MD 21076 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 27 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2009 Beltsville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MOLYY. Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLON CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director MD

Funeral

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Completed

Be ပ

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

h and Mental F

permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau once.

72 hours after

Baltimore, Maryland 21215-0036

2009

/Medical

10a State

attending physician a for use as the burialpage 2 should be certificate

IF FEMALE:

law requires that the death certificate be executed

Physician: The

Hospital or Attending 24 hours after deatl

this

Vital

Division of

Records, P.O. Box 68760,

JUAN PABON

Examine Physician/Medical ۵ Completed funeral director, Be Certification: To filled in by

Medical

31. Date filed (Month, Day, Year)

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ctopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year								
Part II. Other significant conditions of	ontributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown								
			24a. Was an autopsy performed? 1								
25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 ☐ Yes 2 🗶 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 X Other (Specify) HOSPICE								
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	, factory, office	8f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam one)X Nurse Pract	niner: On the basis of examination and/or inve	occurred at the time, date and place stigation, in my opinion, death occ	L. e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)								
29b. Signature and time of contifier	enve	29c. License number 8149792	29d. Date signed (Month, Day, Year)  5/26/09								
30. Name and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person and address of person and address of person and address of person and address of person and address of person and address of person address of person and address of person add	completed cause of death (Item 23a) (Type, Pr		UM, MD 21093								

23c. If yes, outcome of pregnancy

State

completely within 2.

istrar's Signature

Patricia Aronica-Pollak MD Assistant Medical Examiner 31. Date filed (Month, Da egistrar's Signature

30. Name and address of person who completed cause of death (Item, 23a)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 19, 2009

State Registrar

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Constantine Pag		S Stat 1- For State	e of Maryland /	•	rtment c tificate c		Mental F	lygiene		20	00 1000		
		Registrar  1. Decedent's Name (First, Middle,L		Cer	uncate C	Death		Re 2. Date of Deat	g. <b>N</b> o.	6 U	3. Time of Death		
Physici Medical Exami	an/	Constantine Geo		ic				Month May 25, 20		Year	1326 hrs		
		4a. Facility Name (if not institution,		13		4b. City, Town, or Lo	ocation of Dea						
1		Baltimore Washington N				Glen Bernie		Anne Arundel					
Funeral				(In yrs. la	ist birthday)	If Under 1 Year	If Under 24H	rs. 8. Date of Birt	h (MM/DD/	YYYY) 9. Bir	thplace (State or		
Director			XM 2 F	56	Yr	Months Days	Hours Mi	Nov. 1	195	Foreig Co	untryMaryland		
		Usual Residence of Decedent		- 50		5.		1104. 1	, 150		- Alary Tana		
any		10a. State 10b. County		10c. City,	Town or Loca	ition					10d. Inside City Limits		
Q *	Ļ	MD Anne Ar	rundel	Pasa	adena						1 Yes 2 No		
arylar arylar at on	cto	10e. Street and Number				10f. Zip Code		10	g. Citizen	of What Cour	ntry?		
he M	Director	3458 Brookhaven	Road			21122			USA				
ideath with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status	12. Was Decedent	Ever in U.		as Decedent of Hispa		Specify Yes or No-			ican Indian, Black,		
leath r iten	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No			lf .	Yes, specify Cuban, I	Mexican, Puer	to Rican, etc.)		White, etc.			
after (	by F	3 Widowed 4 Divorce	ed If Yes, Give Year		1	Yes 2X No	specify:		Specify: White				
hours after "natural", Examiner		15. Decedent's Education (Specify	only highest grade com	pleted)		ent's Usual Occupatio most of working life. D			16b. Kind	of Business/	Industry		
6 172 h an "n cal E	lete	Elementary/Secondary (0-12)	College (1-4 or 5	+)		nost of working me. E	70 110 1 430 10	ourou,					
5-0036 iled within 7/ Hygiene. I other than	Completed	12	4		Chef					staurant			
Hyging of the		17. Father's Name (First, Middle, La	•			1		me (First, Middle, Maiden Surname)					
2121 ould be fill Mental I marked c event,	Be	Theodore Gus Pag 19a. Informant's Name/Relationship			10h Moili	ng Address (Street a		orge Pap			Zin Codo)		
D 2 shoul and N 7 is m	의			010		Brookhave							
imore, MD 21215-0036 Pages I and 2 should be filted within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than 'or other traumatic event, the Medical.	-	Lynne T. Paduss	is / sist			sition (Name of ceme		Date		ation - City or			
Ore ges 1 of H If it		1 X Buria 2 Cremation	3 Removal from Sta	te c	crematory or o	other place)	, l	1					
timen tmen		4 Donation 5 Other Spec		Gre		thodox Cem		28/09	Bait	imore,	MD or Roa		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens I man attural", or titems 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signat of hera ervice LR	ensee			Name and Address of JCK TOWSON		al Homo			MD 21204		
Physician		23a. Part I. Enter the disease, or co	mplications that caused	the death							Approximate Interval		
/Medical		failure. List only one cause on	each line.								Between Onset and Death		
xaminer		immediate Cause (Final disease or condition resulting in death)	a. Quetiapir  Due to (or as a conse			tion							
		Conventially list anneltions	b.	9001100 01	7.								
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of	f):	-							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a conse	quence of	N.								
ansit de d		events resulting in death) Last	d										
executed ian and al - transit	ical	XUNPENDED	AMENDED 23a	,27,	28a-f,	permE, g8	92 6/4/	09 TT					
	Ned	IF FEMALE:	23c. If yes, outcom	ne of prear	nancv				23d. E	Date of deliver	y		
Box 68760, e death certificate be the attending physici ed for use as the buri	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth	, ,	2 F	etal death 3	Ectopic preg	nancy	М	onth	Day Year		
ox 6 ath ce	sici	1 Yes 2 No 9 Unkno	4 Pregnant at	time of de	ath 5 🗌 (	Other (Specify)							
BC BC he de:	h		3 Olikilowii	h			on in Dart I	23o Did to	phaceo use	o contribute to	the cause of death?		
cords, P.O. B law requires that the d has been signed by the	by	Part II. Other significant condition	is contributing to deatr	DUL HOL FE	esulang in the	rundenying cause giv	ren in Fait i.		bably 4 Unknown				
S, I									24a. Was an 24b. Were autopsy finding				
OFC aw re- as be	Completed							autor			completion of cause of		
Rec The licate h	[등					1 ✔ Yes							
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?					of Death (Chec	k only one)					
of Vital Records,  ng Physician: The law requir ther this certificate has been si meral director, page 2 should b	10 E	1 🗸 Yes 2 No			ER/Outpatie				Residence		er:		
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be refeath. After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the buri		27. Manner of Death  1 Natural 5 Deading	28a. Date of Inju (Month, Day,Y	ry ear)	28b. Time o			28d. Describe unk	how injury	occurred			
ior ttend death.	atic	2 Accident Investig	ation Fu 3/2		unk		s 2 X No						
Division  pital or Attendin  ours after death.  teral Director: A	 E	3 Suicide 6 X Could not be Home 28e. Place of Injury - At home, farm, street, factory, office building, etc.						28f. Location (Street and Number or Rural Route Number, City or Town, State) 3458 Brookhaven Rd					
	Certification:	4 Homicide determined (Specify) Home Pasadena, MD											
To the Hus within 24 h		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  one) One Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
within 7 complete	Medical	)2	and manner stated.	miutiOII di				- actino timo, date					
29b. Signature and title of certifier  29c. License number  O.C.M.E.										onth, Day,Year)			
(Antitella)													
		30. Name and address of person w	•			n Ctroot Dali	oro MD 04	1201					
			istant Medical Exa			in Street, Baltim	ore, IVID 2	1201					
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registra	s Signatu	bar	٧							
Regis	2000	MAY 2 7 ZUU	y prous	po.	7				_				

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**ORIGINAL** 

		1	For State		State o	f Mai	ryland / I	-	rtment of H tificate of L		and Me	ental Hy	giene Reg. No	/ 1111	9 1	6897
			Registrar  1. Decedent's Nam	ne (First, Middle,	Last)							2. Date of De	eath		3. Tim	ne of Death
Physi /Med		_	Paulet	te Marg	garet Pa	ı1ek						May 2	22 Day	2009	5:3	32p <sup>M</sup>
Exam			4a. Facility Name (			,			4b. City, Town, or	Location of	of Death			County of Dea	th	
			Carrol1						Westm					Carroll	# I- · · · (O)	
Funera Directo			5. Social Security N 213-70-5	5175	. Sex 1□ M 2□√F	7. Age 55	(In yrs. last bi	Yrs.	Months Days	If Under Hours	Min.	8. Date of Bir (Month, Di Aug 23	a <i>y, Year)</i>	953		tate or Foreign
and and		-	Usual Residence o 10a. State	10b. County			10c. City, Tow	vn or Loca	ation						10d. Insid	de City Limits
Mary I-f sh	3	0	MD	Carrol1	L		Sykesv	ille							1 🗆	Yes 2∑XNo
h the	3	Director	10e. Street and Nu	ımber					10f. Zip Code				-	izen of What Co	ountry?	
tth will	-		5810 Me1	.ville Ro	oad				21784				US	SA		
er deg		runerai	11. Marital Status		12. Was Dece Armed Fo	rces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Ori an, Mexicar	igin? (Spec n, Puerto P	cify Yes or No Rican, etc.)	0-	<ol> <li>Race - Am- Black, White</li> </ol>		an,
rs affe	1	2	1 ☐ Never Marr 3 ☐ Widowed	ried 2 Married 4 Divorced	d 1 ∐Yes If Yes, Gi Year or D	ve XINC ates:	)	1	□Yes 2∏ No	Specify:				Specify: wh	ite	
2 hou	100	Eed -	/Cnn	15. Decedent's	Education		168	a. Decede	ent's Usual Occup	ation	t of workin		16b. K	ind of Business	/Industry	
ithin 7	1 4	Сотріете	Elementary/Seco		College (1	-4or 5+	)		ind of work done of NOT use retired	dining mos	t or working	g	do	omestic		
iled w Hygie ther th	6		12 17. Father's Name	(First Middle 1:	get)			noi	memaker	18 Mothe	er's Name	(First, Middle	. Maiden	Surname)		
d be f ental   ked ol	0	o pe		Paul Ton	,									Taskeı		
shoul and M s marl	F	2	19a. Informant's N		(Type. Print)		19	b. Mailing	Address (Street	and Numbe	er or Rural	Route Num!	ber, City	or Town, State,	Zip Code)	
and 2 ealth a n 27 is			Crystal	D. Webst	ter (daug	ghte	-		odestone		West	minste				
ges 1 t of H or oth			20a. Method of Dis 1 ☐ Burial 2	sposition  Cremation 3	☐Removal from	State			ition (Name of atory or other place			ate		ocation - City or		te
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Exprinter Invest be notified at		-	4 Donation	5 ☐ Other (Spe	cify)		AII C		y Cremat:		5-24-			esville.		
permi Depa Impo any il	ouce		21. Signature of Fi	x Houx	ut ofer	be	xt		Name and Address  O. Box 19						& Char	pel
			23a. Part 1. Enter the shock, or hea	the disease, or co art failure. List or	omplications that only one cause of e	aused t	he death. Do	not ente	r the mode of dyin	ng, such as	cardiac or	respiratory	arrest,	1	Approx Interva	ximate al Between and Death
Physicia			Immediate Cause disease or condition resulting in death)	ion	_a	L r	3115	-11	C ()	251	170	$\alpha$			CHOCK	and Boatt
/Medica			recurry in death,		Due to	(or as a	consequence	e of):								
		ner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	onditions, nmediate	b Due to	(or as a	consequence	of):								
ecutec ind transi		Examiner	Cause (Disease or that initiated events resulting in death)	r injury	с											
icate be executed physician and the burial-transit			resulting in death,	Luci	Due to	(or as a	consequence	9 01);								
	ipo	edical			d											
eath certific attending p	A // W	IN/IN	IF FEMALE: 23b. Was deceden		23c. If yes, ou		f pregnancy ☑ Fetal deat	h 2□	Ectopic pregnanc	.,				23d. Date of de	elivery	
e deat the att	icio	Physician/m	in the past 12 1 ☐ Yes 2	No		nant at	time of death		Other (specify) _	У				Month	Day	Year
that the de ned by the detached	0	E	9 ☐ Unknown		s contributing to d	eath but	not resulting	in the unc	derlying cause give	en in Part I		23e. Did	tobacco	use contribute	to the cause	e of death?
uires t signe		o o			<b>-</b>				,3			1 🗆	Yes 2	□No 3□ F	robably	4 ☐ Unknown
w requir s been s should	100	ere										24a. Was				dings available
The fav ate has	Ì	Completed										auto perf 1 □Yes	ormed?	death?		n of cause of
sician: The certificate h rector, page		0 e	25. Was case reference	rred to medical					"1"		e of Death	(Check only			M	T 1 1 200 0 =
Physi this c	F	2	1 ☐ Yes 2 ☐ 27. Manner of Dea		Hospital: 1  28a. Date		nt 2 □ ER/C	outpatient Time of		4 ∐ Ni		ne 5 Res		6 Other (Sp	ecity	Etwo
ding Ph h. After thi funeral	100	LOI	1 Natural 2 Accident	5 Pending investigat	(Mon	th, Day,	Year)	Injury	28c. Injur Work	yai k? Yes 2□		8d. Describe	r now mju	ry occurred		
Atten r deat ector: by the	19	IICa	3 Suicide 4 Homicide	6 ☐ Could no determin	t bo	of Injur	y - At home, f	farm, stre	et, factory, office			8f. Location City or To		nd Number or F	Rural Route	Number,
tal or rs afte al Dir	100	Certification:	4 [] Hornicide		Build	ing, etc.	(Specify)					City of Te	own, Stat			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after decider. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Coip	Medical	29a. Certifier (Check only one)		Physician: To the kaminer: On the b and man	asis of	examination a									use(s)
To th within To the	MA	Me	29b. Signature and	d title of certifier	1. 100		LAN		29c. Licens		157		29d. Da	ate signed (Mor	nth, Day, Ye	ear)
			- W	mok	WW	7	vi)			(30	~		US	, 12	5-	01
le V			30, Name and add	iress of person wi	ho completed caus	se of de	ath (Item 23a)	(Type, P	Print)	WE	イント	11257	4	my)	2116	万
	State	•	31. Date filed (Mor	nth, Day, Year)	32. F	Registra	r's Signature	0. 1	j							
Regi	strai		MAT	27 2009	peren	-	B. 140									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** STACY PASS 8:30 AM MAY 22,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth (Month, Day, Year 10/04/1936 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F 219-30-2682 72 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No must be notified MD BALTIMORE BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 6603 CHIPPEWA DRIVE 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No WHITE Specify Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **PHARMACIST** PHARMACY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be REUBEN PASS KATIE MAINEN ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARLYN PASS / WIFE 6603 CHIPPEWA DRIVE, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 □ Cremation 3 □ Removal from State BETH EL MEMORIAL PARK 05/24/2009 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mall 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of India) that initiated events Due to (or as a consequence of): Examiner Physician/Medical þ Completed Be P Certification:

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Director; d in by the

Baltimore, Maryland 21215-0036

within 24 hours aft To the Funeral Di completely filled in

0 State

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NAY 2 7 2009

resulting in death) Last	Due to (or as a consequent	ence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions  END STAGE	contributing to death but not result		cause given in Part I.		se contribute to the cause of death? √No 3 □ Probably 4 □Unknown
RESPIRATOR	ARTERY Y FAILUR	BISER.	SE	24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 □ E	R/Outpatient 3 ☐ D	OCA Other: 4 Nursing	Home 5 ☐ Residence	3 □Other (Specify)
27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
3 Suicide 6 Could not 4 Homicide determine		ne, farm, street, facto	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
29a. Certifier 1/2 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knov aminer: On the basis of examinat and manner stated.	vledge, death occurre ion and/or investigation	d at the time, date and pla on, in my opinion, death oc	ce, and due to the cause(s) curred at the time, date and	and manner as stated. It place, and due to the cause(s)

29c. License number

D0063327

29d. Date signed (Month, Day, Year)

22,

2009

DHMH 17 Rev 1/2001

Registrar

GIZAW WOLDEHINGT, MD 2434 W. BETVEDERE AVESBALTIMORE, MD 21215

Wowstrewor

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#8perTNF, G892, 6/4, 09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Yerry 11:05 PM 2009 May 21 /Medical 4a. Facility Name (If not institution, give street and number) County of Death Baltmore MD City, Town, or Location of Death Bathmore City Examiner Johns Hopkins Bayvew Carelenter If Under 1 Year | If Under 24 Hrs. Social Security Numbe 6. Sex 8. Date of Birth (Month) 89, Year)
FEB 21 1923 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖫 F 86 Months Days Hours Min. MARYLAND 216-14-0568 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner aust be nothered 1 ☐ Yes 2 X No Director BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 21208 402 SUDBROOK LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No WHITE 2 Specify 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) \$\frac{1}{2}\$ should be filed within \$\frac{7}{2}\$ and Mental Hygiene.
7 is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION **TEACHER** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KLEINBERG DEITCHMAN EVA HERMAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f and 2 s Health ar em 27 is permit. Pages 1 and Department of Health Important: If item 27 any injury or other tra PAISLEY COURT BALTIMORE, MARYLAND 21221 GEORGE PERRY, JR. / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/24/2009 HAR SINAI CONG. OWINGS MILLS, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. sutt. 8900 REISTERSTOWN ROAD-PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. a. a. Due to (or as a consequence of): asa days disease or condition resulting in death) /Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): requires that the death certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ► No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.O. the detached 9☐ Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate funeral director, pag 2 No 1 ☐ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medic examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □ Yes 2 1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Kl Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) May 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 KIMBERLY VAUGHN CRNP 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 0.23 AM **Physician** 09 23 5 Darcell Reeves Dennise /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore, Good Symarityn Huspital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Min. Hours Months Days 1 □ M 2 🕱 F MD 49 26 215**-**70**-4772** Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location Y☐Yes 2☐No **Funeral Director** Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. 2601 Madison Ave Apt 405 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2√ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Cook 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Irene Nelson Nathaniel Reeves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joy Reeves-Daughter 3 Millpaint Lane, Owings Mills, Md 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MD Burial 2 Cremation 3 Removal from State King Memorial Park 5/28/09 Woodlawn, Md T⊟Qonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death ate Cause (Final 5 days Heuse myolardial interction disease or condition resulting in death) Due to (or as a conse tuence of): arten Coronary 6 years disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cardiovascular dispare Artheroscleratic 40015 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown End direase Stage 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DM 1 ☐Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1€ No 1- Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

**Physician** /Medical Examiner requires that the death certificate be executed

**Funeral** 

Director

e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or items 23a or 28a-f show

ltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "hedical Examinat must be notified at

ent of Health and Mental Hit: If item 27 Is marked oth y or other traumatic even

permit. Page:
Department o
Important: If i
any Injury or

Pages 1 and 2

burial-tra attending physician for use as the burial After this certificate has been si funeral director, page 2 should

Records,

Vital

of

or Attending Division

4 hours after death death.

24 hours a Hospital

the

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filled in by

completely

State Registrar

**JUNNEQ** 

Examiner Medical Certification: To

Physician/Medical Completed by Be

Date of Injury (Month, Day, Year) 5 ☐ Pending investigation

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

Res 000

och Raven Blud

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601

MD MONTHIDA 31. Date filed (Month, Day, Year)

Leonell

32. Registrar's Signature

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2:40 PM M May 26, 2009 Nancy Dulaney Rowe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Broadmead Health Care Center Cockeysville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🖼 E 92 Director 218-07-2668 08/31/1916 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 23a 21030 USA 13801 York Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō Specify: White 1 ☐ Yes 2 No Specify: 2 3 ₩idowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Sim Dulaney Ethel Shriner ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy-Bets Hay/Daughter P.O. Box 24 Riderwood, MD 21139 Department of Health Important: if Item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 2009 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory; 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives Ralli 8717 Green Pastures Drive Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) **Physician** /Medical Due to (or es e consequence of): Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 4 🔲 Pregnant et time of death ☐Yes 2 ☐No P.0. by the 9 Unknown 9 Unknow certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 12 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 I wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director; A d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely file Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

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09-03991 Roy Rainey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Roy Rainey		State of Maryland / Department of Health and Mental Hy	giene		
		- For State Certificate of Death	Reg.	No. 200	9 1590
Physicia		1. Decedent's Name (First, Middle,Last)	2. Date of Death	too to to	3. Time of Death
Medical Examin		KOY Kainey	May 19, 200	Day Year D9	1740 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	th
		1809 N. Monroe Street Baltimore		NA	
Funeral	$\neg$	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	┥	` 1 ^	irthplace (State or Foreign ountry)
Director		3(5-47-6932) 1 M $2 - F$ ( 8 Yrs.   Months   Days   Hours   Min.	03-63		nare land
	F	Usual Residence of Decedent			· way sore
any	ı	10a. State 10b. County 10c. City, Town or Location	-	-	10d. Inside City Limits
p m	٠,	Md. N/A Baltimore			1 Yes 2 No
arylar	융	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
5-0036  ed within 72 hours after death with the Maryland Tygiene. other than "matural", or items 23a or 28a-f she the Medical Examiner must be notified at once.	Director	1809 n. monre St. 2,217		US	A
s 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spo	ecify Yes or No-	14. Race - Ame	rican Indian, Black,
item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		. White, etc.	2 /
ter d		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify:	SIACIL
urs af	핡	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w		6b. Kind of Business	s/Industry
hin 72 hours ee. than "natur edical Exam	뢂	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retire	ed)	Back	o. city
D36	힏	12th NA Laborer			J
5-00 led wi Hygier other	Completed	17. Father's Name (First, Middle, Last)	(First, Middle, Ma	iden Surname)	
	Be	Jacob Kainey Bern	ice		
2121 2121 Duld be f I Mental		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R	ural Route Numb		
O 48 8 €		Sylvester Jones - Friend 843 N. Bentalov	St. Ba	leto, me	4. 21216
e, M I and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		2Cc. Location - City of	or Town, State
AOFE ages I nt of H it: If ii		Durial 2 Cremeton 3 Removal from State	27-09	Dunda	CK, MD.
	1	4 Donation 5 Other Specify:  21. Signature of Fune all Solvic Licensee  22. Name and Address of Facility 27	-		Bicc
Balt permit Depart Impor		Cong Pimarch f	d 2	Tricion	nd,21229
Physician	-	23a. Party. Enter the disease, or complications that caused the death. Do not enter the modelof dying, such as cardiac or		t, shock, or heart	Approximate Interval
/Medical	- 1	failure. List only one cause on each line.			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
	- 1	h			
	호	Sequentially list conditions, If any, leading to immediate  Due to (or as a consequence of)			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated  c.  Due to (or as a consequence of):			
led nsit	<b>~</b>	events resulting in death). Last			
be executed incian and unial - transit	dical	d.  UNPENDED AMENDED			
				Loo Louis Car	
Box 6876( e death certificate the attending physelfor use as the b		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnan	ncv	23d. Date of delive Month	Day Year
K 66	cia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			,
BOy death	ysi	1 Yes 2 No 9 Unknown 9 Unknown			
that the d	直	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
P.(	ğ	Chronic alcohol abuse	1 Yes	2 No 3 Pr	obably 4 🗹 Unknown
ords, we require been so thould	鲁	<del></del>	24a. Was an		autopsy findings available
CO law has	필	<u> </u>	autopsy	ed? death?	
tal Rec	Completed		1 <b>✓</b> Yes 2	No 1 <b>✓</b> `	res 2 No
Vital ysician: ysician:	8	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing		esidence 6 🗸 Oth	C
Physical direction	의	Yes 2 No		w injury occurred	er; Scene
ding Ph	ᇹ	1 Natural 5 Pending (Month, Day, Year)	200. 2000. 100 110	w mjary boodings	
Sior Attend r death ector: by the	듏	2 Accident Investigation	Of Leasting (Ch		Const Davida Marahan City
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death the certificate has been signed by filled in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Certification:	3 Suicide 6 Could not be	or Town, Sta		Rural Route Number, City
bspi hou y fill		4 Homicide	4 - 4 - 9	(-)d	
To the How within 24 h	हु	29a. Leftiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at			
To the within comp	Medical	and manner stated.			
	2			29d. Date signed (M	omin, Day, Fear)
77		MIPLE M. O.C.M.E.		May 20, 2009	
OCME	ı	30. Name and address of person who completed cause of death (Item 23a)	0400:		
	_]	Meliss Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** May 25, 2009 11:24 PM /Medical Annie May Reed - Mack 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Middle River 1149 Seneca Road Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2√2 F Months Days Hours Min. Director 217-16-6797 98 7/7/1910 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 ☐Yes 2 X No Maryland Baltimore <u>Middle River</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1149 Seneca Road A. Funeral S. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 □Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ William Henry Rhea Annie Margaret Thiess 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middle River, Maryland 21220 Bernard Eckert, Jr. (Son-in-law) 910 Middle Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/29 2669 Holly Hill Mem. Gard. Baltimore, Maryland <sup>22.</sup> Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee PA Essex, Maryland 21221 chail 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Musin Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Luna cancal MONXH disease or condition resulting in death) /Medical Due to (or all a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I β 20 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \triangle \) Nursing Home \( \frac{\frac{1}{2}}{2} \) Residence \( 6 \) Other \( \frac{Specify}{2} \) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

and burial-trar Box 68760, attending physician the as nse for P.O. Division of Vital Records, page 2 s has certificate e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifical letely filled in by the funeral director, p the

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mentai Hygiene. Important: If Item 27 is marked other than "naturai", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Examinat must be notified at

Baltimore, Maryland 21215-0036

within To the 10

State Registrar

Medical

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

29b. Signature and title of certifier

and manner stated.

29c. License number 000

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 6 0

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

MAY 27 2009

Gary Friedman M.D. 1245 Eastern Blvd. Baltimore, Manyland 21221

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 per Fh 9891 5/27/09 TT
State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25 25 Year 2009 8:30 AM Jeanetta Sturdivant MAY Pauline 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. <u>Union Memorial Hospital</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Age (In yrs. last birthday) Year) 1 □ M 2 🙀 F Yrs. 75 MD 34 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State X□Yes 2□No Baltimore NA MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21216 4231 Norfolk Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Black Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dept of Social Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Service 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Brown Samuel Henry Hardy 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4231 Norfolk Ave, Baltimore, Md 21216 Wilbert V. Sturdivant Sr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Owings Mills, Md Garrison Forest Vet 6/4/09 Donation 5 ☐ Other (Specify) 21. Signs tu 22. Name and Address of Facility of)Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 DAYS PNEUMONIA Due to (or as a consequence of): 2 MONTHS METHSTATIC LUNG CANCER Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTASES 2 1 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

/Medical Examiner requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760. Ö s been signed by the should be detached ₫. Division of Vital Records, cate has t page 2 s certificate Physician; this After t or Attending To the Hospital

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

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Funeral

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Completed

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Certification: To

Medical

State Registrar

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

so 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.

1item 27 is marked other than "natural", or items 23a or 28a-f show than traumatic event, Ite Medical Exeminer must be notified at

Pages 1 nent of H ant: If ite ury or ot

Department of Important: If any Injury or once.

**Physician** 

MEMORIAL HOSPITAL, BALTIMORE M.D. UNION OLARV 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

AT2438946

MAY 25, 2009

09-04128		Please Type	or Print in Blee of Maryland	ack Inde	elible l	nk. Ensi	ure All Co	pies Are Leg L'Hygiene	ible.	
Connie Lynn Skillm		State State	e of Maryland	Certit	ficate o	f Death	and Monta		. No. 2	009 1690
Physician		egistrar . Decedent's Name (First, Middle,L	ast)					2. Date of Death Month	Day Year	3. Time of Death 0845 hrs
Medical Examine	T	Connie Lynn	Skillmar	1		4h City Town	, or Location of D	May 24, 20	9 4c. County of D	
)	4	a. Facility Name (if not institution, g 3311 Nova Scotia Road	ive street and number	)		Aberdee		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Harford	
Funeral	5		Sex 7. Ag	je (In yrs. last	birthday)	If Under 1			(MM/DD/YYYY)	Birthplace (State or Foreign Country)
Director		217-80-3278 1	M 2 XF	50	Yr		Days Hours	Min. 12/03/	1958	Maryland
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ow any	ı	0a. State 10b. County MD Harfor	d		berde					1 Yes 2 X No
id PAES with the Maryland s 23a or 28a-f show s e notified at once.	Director	10e. Street and Number	<u>u</u>		Derde	10f. Zip Cod	de	10	g. Citizen of What	t Country?
the Ms a or 29	5	3311 Nova Scoti	a Road			2100	)1		U.S.A.	Black
with	Funerat	11. Marital Status  1 Never Married 2 Marr	12. Was Deceden		. 13. W	as Decedent o Yes, specify C	f Hispanic Origin uban, Mexican, P	? ( Specify Yes or No- querto Rican, etc.)	14. Race - White,	American Indian, Black, etc.
r death			eu	X No		Yes 2X	No specify:		Specify: W	Mite
us afte	≧ -	3 Widowed 4 Divorce  15. Decedent's Education (Specific	or Dates:	mpleted) 1	I6a Decede	ent's Usual Occ	cupation (Give kir g life. DO NOT us	nd of work done	16b. Kind of Busi	ness/Industry
72 hou	<u>ĕ</u>	Elementary/Secondary (0-12)	College (1-4 or	5+)		maker	gille. DO NOT us	se retired)	l Own Hom	ne l
003( within jene. M. di	Completed	11 17. Father's Name (First, Middle, L.	act)		HOILE		18.Mother's	Name (First, Middle, M		
21215-0036 Juld be filed within 7 Mental Hygiera marked other than ic event, the Medir	ည်  Be	Walter Kilgore,						. Vaught		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other with an "natural", or items 23a or 28a-f sho injury or other traumatic event, the Middle Examiner must be notified at once	ᆰ	19a. Informant's Name/Relationship	(Type, Print )		19b. Maili	ng Address (	Street and Numb	er or Rural Route Num	ber, City or Town	, State, Zip Code) Grace, MD 21078
altimore, MD mit. Pages I and 2 she spartment of Health and prortant: If item 27 is jury or other trauman	ļ	Brian Kilgore/E	rother	20h Pl	1	osition (Name		Date	20c. Location - 0	City or Town, State
Ore, es l ar of Her Ir ite	-	20a. Method of Disposition  1 Bunal 2 X Cremation	3 Removal from S	cre cr	ematory or	other place) mation S		05/26/2009	Hanover.	Maryland
timent rtant:	-	4 Donation 5 Other Spe 21. Signature of Funeral Service	cify:	ALGC			dress of Facility		,	Services
Bal permi Depar Impo injur	- 1	KM13-	1		7	522 Co	nnelley	Drive, Ste	.N, Hand	over, MD 21076
Physician		23a. Part I. Enter the disease, or cr failure. List only one cause o								
/Medical aminer	1	Immediate Cause (Final disease	a. Atheros			rdiovas	cular d	isease and	fatty 1	iver
	-	or condition resulting in death)	Due to (or as a cor	isequence or)	•					
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence of)	):					
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and	cal E	<b>Y</b>	d. AMENDED 2	3a.27.	perME	, g892	6/29/09	TT		
ox 68760, eath certificate be ext attending physician for use as the burial.	ledic	XUNPENDED  IF FEMALE:	23c. If yes, outo						23d. Date of	delivery
3876 rtiffcat ing ph	sician/Medi	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2	Fetal death		pregnancy	Month	Day Year
Box 68760, e death certificate be the attending physic ed for use as the bursed for use	sici	1 Yes 2 No 9 V Unkr	7	at time of dea	5	Other (Specif	y)			
O. B. it the de lacked if	Phy	Part II. Other significant condition	ons contributing to de	eath but not re	sulting in th	e underlying c	ause given in Pa			bute to the cause of death?  Probably 4 Unknown
, P.O. ires that the signed by signed by I be detach	d by							24a. Was	s 2 <b>√</b> No 3	Were autopsy findings available
Cords, law require, has been e 2 should	Completed							auto	psy p	orior to completion of cause of death?
Reco	Com						(D. 1)	L'Aut	2 No 1	✓ Yes 2 No
tal Rec	Be	25. Was case referred to medical examiner?	Hospital:	atient 2	ER/Outpati		Other:	(Check only one)  Nursing Home 5	Residence 6	✓ Other: Scene
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ion of lending Pheath.	tion	1 X Natural 5 Pend	Lingtion				1 Yes 2			
Division of Vital Records, tal or attending Physician: The law requirers after death.  "I Director: After this certificate has been siled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could	not be	f Injury - At ho	ome, farm, s	treet, factory,	office building, et	c. 28f. Location or Town,		er or Rural Route Number, City
Divisior  Hospital or Attend 24 hours after death Funeral Director:	Cer	4 Homicide	ysician: To the best o	f I d a d	- death o	neurrod at the l	ime date and pla	ace, and due to the cal	use(s) and manne	r as stated.
DIVI To the Hospital or within 24 hours after To the Funeral Dir	Medical	(Check only one) 2 Medical Exam	niner:On the basis of	examination a	nd/or inves	tigation, in my	opinion, death oc	curred at the time, dat	e and place, and	due to the cause(s)
To with To con	Mec	29b. Signature and title of certifie	and manner stat	ea			License number		29d. Date sign	ned (Month, Day. Year)
		Mouset	melkul	L			O.C.M.E.		May 25, 20	
		30. Name and address of person	who completed cause Assistant Medic			1 Penn Str	et, Baltimore	e, MD 21201		
<i>X</i> 0 √	nt.	Margarita Korell MD.		strar's Signati	ure.					
St Regist	ate trai		2009 Zen	we	1. A	raves				

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 4:45 P M 23 2009 Betty Lou Schildt May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laurel Howard 9230 Gross Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🔀 F Yrs Virginia 78 Apr. 26, 1931 Director 217-32-2737 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evanine must be notified at 1 ☐ Yes 2X No Director MD Howard Laurel 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 9230 Gross Avenue 20723 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No 2 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) General Electric Quality Control 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Virginia Barthalow ٥ Chester Stone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important: If Item 27 is any injury or other trau Barbara L. Doane/Daughter 329 Ferndale Road, Glen Burnie, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/27/2009 Burtonsville, MD Union Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 20707 M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumumo of Examine burial-trans Due to (or as a consequence of): Box 68760. aftending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy law requires that the death Month Day for in the past 12 months? 1 ☐ Yes 2 XNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached in 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🔑 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐Yes 2 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Mopth, Day, Year) 28c. Injury at Work? 5 Pending investigation al or Atternation after death. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 🖺 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month May **Physician** 9:15 an M 21 Frances Simmons /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Lutheran Village Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ XF 194-14-3590 91 Sept 6 Director 1917 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exemination to conflict at once. 10d. Inside City Limits 10a State 10h County 10c. City Town or Location Director MD 1 ☐ Yes 2 ▼No Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 St. Luke Circle 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give 7 Year or Dates: Specify Specify: white þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Motor Elementary/Secondary (0-12) College (1-4or 5+) clerk Vehicles 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Kamenske Mary Giernacky ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Stauffer (daughter) 2709 Aspen Dr., Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 5-23-09 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a consequence of, Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Þ 2 ☐ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) this c Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

nd address of person who completed cause of death (Item 23a) (Type, Print)

033561

less way #11+ Elders bug , md

			For State Registrar		State of	of Mary	/land /		rtment of l tificate of		nd Mer		giene Reg. No.	2001	9	16908
			Decedent's Name (First, M	ddle, Last	)						2.	Date of Dea Month	ath Day	/ Year		3. Time of Death
	Physicia /Medic		WILTON	FRAD	ICIS	STIT	ELY	JR			MA			2009		:35P M
	Examin		4a. Facility Name (If not institu						4b. City, Town,		Death			County of De		
J.			FREDERIC					hirthdous)	FREDEF	If Under 24	Hrs I o	Date of Birt		REDERI		e (State or Foreign
	Funeral Director		5. Social Security Number 214-36-1192	6. Se	x MIM 2□F	7. Age {II	n yrs. last b 71	Yrs.	Months Days		Min.	(Month, Da	y, Year)		Country)	yland
			Usual Residence of Decedent				/ 1						J/ 1	J J 1		
	ryland show	_	10a. State 10b. Cou	nty		10	c. City, To								10d.	Inside City Limits 1 X Yes 2 □ No
	Ba-f s	ecto		rroll			We	stmi	nster				10- 00	izen of What 0	Country	
	with the	Ë	10e. Street and Number	QL-					10f. Zip Code	7				S.A.	Journa y	:
	ns 23	<b>Funeral Director</b>	336 Bishop	Ct.	12. Was Dec		r in U.S.	13. \	2115 Vas Decedent of fYes, specify Cul		? (Specify	y Yes or No	_	14. Race - An		Indian,
36	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Medical Eventine must be natified an once.	by Fur	1 □ Never Married 2 □ I 3 □ Widowed 4 🗷 Divor		If Voc C	2 🗌 No	SEE EC		fYes, specify Cui I∐Yes 2⊠No		Puerto Ric	an, etc.)		Black, Wh		е
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2	hin 7: e. an "n	Completed	(Specify only hi			) (1-4or 5+)		(Give life. i	kind of work done OO NOT use retire	e during most of ed)	t working					
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<u> </u>	hould d Mer marke matic	은	Wilton F. St				10	Oh Mailir	ng Address (Stree			abeth			Zin Co	nde)
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Baltimor	ermit. spartn nporta ny Inju		21. Signature of Funeral Sen	rice/Licens	9	1			. Name and Add		Har	tzler	Fun	eral H	ome	
n —	20 <b>2 2 3</b>		Dava	$\wedge$ $\wedge$	MOM	ULL			404 S. M					MD 217		
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F	Physician /Medical	П	Immediate Cause (Final disease or condition resulting in death)	_	-	diac .										
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	_	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		b. Ven	o (uras a o	unsequenc	moth:	llation							
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8/60,	icate be executed physician and the burial-transit	E E	resulting in death) Last	1		o (or as a co	•		pathy							
	ificate be of physiciar as the buri	edical		1070	d	auca	oar ar	.Omy C	padily		S1147					
C. Box	ician: The law requires that the death certificace has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			e birth 2 D gnant at tin	Fetal dea	ath 3	☐Ectopic pregnai ☐Other <i>(specify)</i>				19	23d. Date of o Month	delivery Da	
7	that the ed by detacl	Ph	Part II. Other significant cor	ditions co	ontributing to	death but n	ot resulting	g in the u	nderlying cause g	iven in Part I.		23e. Did 1	obacco	use contribute	to the	cause of death?
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ecord	aw rec as bee 2 shou	Completed										24a. Was		24b. Were	autops	y findings available letion of cause of
r	The law are has be page 2 sh	E O											psy ormed? 2√□No	) death	i? 'es 2	
VITA	ctor, p	Be	25. Was case referred to me examiner?	1-						26. Place o	f Death (0					
5	Physician: this certific ral director,	ျင	1 ☐ Yes 2 ☐ No						" 3 L DOA					6 ☐ Other (S	(pecify	
Ĕ	ing F	in oi	27. Manner of Death 1 □ Natural 5 □ Pe		28a. Dat (Mo	e of Injury onth, Day, Yo		b. Time o Injury	W	uryat ork? ⊒Yes 2 ⊒No		d. Describe	now injui	ry occurred		
UNISION	Attend death ctor y the	ficat	3 □ Suicide 6 □ Co	estigation uld not be termined	28e. Plac	ce of Injury	- At home,	, farm, sti	eet, factory, office			f. Location (	Street ar	nd Number or	Rural F	Route Number,
⋛	al or A	Certification:	4 ☐ Homicide de	terminea	buil	ding, etc. (	Specify)					City or To	wn, State	e)		
1	To the Hospital or Attending Physician: within 24 hours after deal. To the Funeral Director After this certific completely filled in by the funeral director,	Medical C	29a. Certifier  (Check only one)  Certifier  2 Med	ifying Phy ical Exam	iner: On the	he best of restance basis of example to the basis of e	kamination	dge, deat and/or ir	h occurred at the	time, date and opinion, death	place, an occurred	d due to the	cause(s date an	s) and manne od place, and o	r as stat due to th	ted. ne cause(s)
	To the Within To the Somple	Me	29b. Signature and title of ce	rtifier					29c. Lice	nse number			29d. Da	ate signed (Mo	onth, Da	ay, Year)
			Som						MDH	64135			05/	23/200	19	
			30. Name and address of pe	son who c					Print)					5.5		
			Safrina			West			et Fred	derick,	Md 2	21701				
	Sta Registr		31. Date filed (Month, Day,			Registrar's			and							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per inf 8892 6-15-09 vt
State of Maryland / Department of Health and Mental Hygiene 2009

1- State amend item 8 per fh g892 6-16-09 refracate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year THOMAS 10.45A.M RVIN 2000 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Baltimore Randallstown Northwest Hospital 8. Date of Birth (Month Pay Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours Months 1**√** M 2□ F Vrc MD 218-28-1874 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 👿 No Owings Mills Baltimore MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number A. Dorset Hill 21117 U.S.A. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married X Married 1 ☐ Yes 2**X** No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steamship Trade 12th grade lyr Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beulah Regusters Earl Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) A. Dorset Hill Ct, Owings Mills, Md 21117 Fannie Thomas-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 5/29/09 Owings Mills, Md 21. Signature of Fineral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 mes Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEMORRHAGE REBRAL disease or condition resulting in death) Due to (or as a consequence of): Dusity (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KINNGYDISGASE ERTENSCON CHRONIC 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes 2 ☐ No DIABETES MELLITUS 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2√2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 ☐ Accident

Physician /Medical Examiner Examiner

physician and s the burial-trans

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page 2 certificate has

director

After this of funeral dire

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within 24 hours a

To the Funeral I

completely filled Hospital

Physician/Medical

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Completed

Be

Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

P.O. Box 68760

Division of Vital Records,

law requires that the death certificate be

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other fraumatic event, the Wedon Express must be notified a once.

Saltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

28a. Date of Injury (Month, Day, Year)

and manner stated.

5 Pending investigation 6 ☐ Could not be determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D54288

NORTHWEST HOSPITAL

RANGARADAN Kamaswamy

State Registrar 31. Date filed (Month, Day, 32. Registrar's Signature Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 10:20 PM **Physician** 2009 Sue Thomas Turner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Olnu Montgomery Hospital Gen eral If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth (Month, Day, Year) 05/19/1913 5. Social Security Number Age (In vrs. last birthday **Funeral** Days Mary Land Months Min. 1 □ M 2 💢 F 134-36-1147 96 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It. Medic: Eventing the contract of the con 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 ☐Yes 2 No Funeral Director Sandy Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20860 17401 Norwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🗽
If Yes, Give
Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2X No Completed by 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) University Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eliza Bentley Frederic Thomas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20861 233 Ashton Road, Ashton, MD Rosalind T. Zuses/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Cremation Services 05/27/2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensie 7522 Connelley Drive, Ste.N, Hanover, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Kight **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial. P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ş 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown s been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 : autopsy 2 No 1 ☐Yes Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 5 Pending Investigation Division To the Hospital or Attending 1 Natural ours after death.
neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2009 B ich huon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Billiman M. Jinh ISIO) Prince 20832 31. Date filed (Month, Day, Year. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 6:00 A Evangelina Torres May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges
9. Birthplace (Sta Laurel
If Under 1 Year 605 Fairlawn Avenue If Under 24 Hrs. (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Year) **Funeral** Months Days Hours Min 1 M 2 X F 01/05/1918 Columbia 216-06-8718 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, If a Medical Experient must be notified at 1x Yes 2 □ No Director MD Prince Georges Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 Columbia 605 Fairlawn Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 √ Yes 2 □ No Specify White <u>\$</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) perion. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatie. Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Belen Rios Eliecer Torres ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 605 Fairlawn Ave., Laurel, MD Fernando A. Urrea/Son 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Ardent Cremation Services | 05/26/2009 | Hanover, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ardent Cremation Services 21076 7522 Connelley Drive, Ste.N, Hanover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and the burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ■ No 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Hospital: Other: 4 Nursing Home 2 No 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sujcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed Attending Physician: To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

> State Registrar

Medical

4 \ Homicide

(Check only one)

nd title of certifier

29a. Certifier

29b. Signature

of person, who completed cause of death, (Item 23a) (Type, Print) 30. Name and address 0 e 31. Date filed (Month, Day,

and manner stated.

Descritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

		For State Registrar	State of	Marylar		artment of rtificate of		ind M	_	giene Reg. No.	009	16912
Physicia		1. Decedent's Name (First, Midd Charlie Tim	, , ,						2. Date of Dea Month	Day	2009	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution	-	nber)		4b. City, Town,	or Location of	f Death		4c. Co	ounty of Death	
Funeral Director		5. Social Security Number 247-54-8255		7. Age <i>(In yrs.</i>	last birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Birt (Month, Da 2 - 27 -	y, Year)	9. Birthp Cour SC	place (State or Foreign ntry)
e Maryland Ba-f show	ector	Usual Residence of Decedent	/	10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits 1   Yes 2  No
th with th	Funeral Director	10e. Street and Number 3415 Lyndal	e Avenue			10f. Zip Code					n of What Cour SA	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it as Medical Examinar must be notified a once.	by	11. Marital Status  1 □ Never Married 2 □ Mar  3 □ Widowed 4 □ Divorced	I ITYES GIV	ces? 2 No e No	1	Nas Decedent of fYes, specify Cu I □Yes 2€ No	ban, Mexican,	gin? (Spec , Puerto P	cify Yes or No- Rican, etc.)	-	. Race - Americ Black, White, pecify: <b>Afri</b> <b>Ameri</b>	etc. Can
within 72 he giene. r than "natu	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 8th	nt's Education est grade completed)  College (1-	-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use retii Labo:	e during most ed)	of workin	g		of Business/Ind	dustry
ld be filec lental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, McKinley Ti					18. Mother		(First, Middle,		ırname)	
and 2 shou salth and M 27 is mar er traumat	-	19a. Informant's Name/Relations Sarah Timmon	ship (Type. Print)			ng Address <i>(Stree</i> Lynda:	et and Number	r or Rural	Route Numbe	er, City or T		Code)
Pages 1 ament of He tant: If Item		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (5	Specify)	(	emetery, cren .yview	sition (Name of natory or other pi Crema	tory 5	5/27		Balt.		
Departi Departi Import any in	1 1	21. Signature of Fine al Service	Licensee		5	Name and Add	ress of Facility Lair R	Har Rd,B	i P. ( alt.,1	Close	F.Sv 1206-5	s,P.A 105
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events	a. Se Due to (c	aused the deat ach line. EPSIS or as a consect EUM ( or as a consect	uence of):	er the mode of d	ying, such as o	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
cate be physicia the bur	dical	resulting in death) Last	Due to (d	or as a consec	uence of):							
the death certific by the attending pached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 Feta ant at time of	al death 3	Ectopic pregna Other (specify)	ncy			23	d. Date of delive Month	ery Day Year
equires that en signed l ould be det	þ	Part II. Other significant conditions STAGE RE			-				23e. Did t		,	he cause of death? bably 4 🗆 Unknown
siclan: The law requires that the de certificate has been signed by the rector, page 2 should be detached	e Completed	DISEASE G GASTRECTOM 25. Was case referred to medica	17	, CA	STOMA	CH S/P			1 □ Yes	rmed?		opsy findings available impletion of cause of
this di	ertification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendii 2 Accident invest 3 Suicide 6 Could	Hospital: 28a. Date of (Month) igation not be	of Injury h, Day, Year)	ER/Outpatier  28b. Time of Injury	28c. In	tther: 4 Nur jury at ork? Yes 2 N	rsing Hom 2	8d. Describe I	dence 6 [		fy) al Route Number,
spital or / nours after neral Dire / filled in b	O	4 ☐ Homicide deterr	ng Physician: To the	best of my kno	<i>fy)</i> owledge, deatl	n occurred at the	time, date an	d place, a	City or To	vn, State) cause(s) a	and manner as	stated.
ro the Ho vithin 24 h ro the Ful completely	Medical	(Check only 2 Medical one)  29b. Signature and title of certifie	and mann	asis of examina	ation and/or in	vestigation, in m	y opinion, deat	th occurre	ed at the time,	date and p	signed (Month,	o the cause(s)
- > - 0		30. Name and address of perso	) who completed cause	M_D e of death (Iter	m 23a) (Type,	Print)	3 000		,44.	05	/24/	2009
Stat	te	SAYED KA2	2601 6	OCH RE	TVEN (	3LVD R	BALTIN	10NE	MD	2123	59	
Registra	_	MAYSTON	Server 32. Re	1. 1	parka							

09-04130		Please Type or Print in Black Indelible Ink. Ensure All Copie		ible.		
Quentin Tucker		State of Maryland / Department of Health and Mental H	ygiene	-	2000	100
		Registrar Certificate of Death		j. No. 🛮 💪	2009	109
Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Yea	3. Time o	
Medical Exami	ner	Guentin lucker	Month May 24, 20	09	1150	nrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of	of Death	
		5430 Park Heights Avenue #303 Baltimore		NA		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I funder 24Hrs	_	(MM/DD/YYYY		
Director		213 - 32 - 3623 1X M 2 F 72 Yrs. Months Days Hours Min	9-9-	1936	Foreign (Country)	land
	t	Usual Residence of Decedent			J	
, L		10a. State 10b. County 10c. City, Town or Location				le City Limits
ne Maryland or 28a-f show	ř	Ad N/A Bath more			1 XY	s 2 No
aryla	ctc	10e. Street and Number 10f. Zip Code	10	g. Citizen of Wh	nat Country?	
he M	Director	5430 Park Heights tre 21215		4.	S.A.	
vith t		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-		- American Indian	. Black.
ath v	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White		,
er de		1 X Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	Black	
ns afi	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	work done		isiness/Industry	
2 hou	ted.	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use reti			,	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at one.	To B	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or			n State Zin Code	1
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nd 2 salth em 2	1	20a. Metylod of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Location	- City or Town, Sta	te
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Page Page nent ant:		4 Donation 5 Other Specify: Green mount (rent) 1-	28-2009	Toald	, bd.	
alti rmit. spartr sport jury	I	21. Similar of Fundral Service Licensee 22 Name and Address of actility	tunk	al Seri	Vieu R	₹.
<b>ល</b> ៩១៩ :		Coulon . Nandan 1711 Accorded st.	1/50/10	· Md.	212/7	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arre	st, shock, or he		mate Interval on Onset and
/Medical	2.3	Immediate Cause (Final disease a Atherosclerotic cardivoascular disease	99			Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):				
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68760, certificate be adding physici ise as the buri	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance	e nov	23d. Date of Month	f delivery Day	Year
Ox 687 eath certific attending p	iar	past 12 months?	ancy	MOHIT	Day	real
Records, P.O. Box The law requires that the death teate has been signed by the atte page 2 should be detached for u	Ś	1 Yes 2 No 9 Unknown 9 Unknown				
s, P.O. Box nires that the death signed by the atter	됩	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	pacco use contr	ribute to the cause	of death?
P.C S that	٥	Chronic alcoholism	1 Yes	2 No 3	Probably 4	Unknown
duire quire	ted		1 24a. Was a	n 124b.	Were autopsy find	ngs available
OFC aw re as be 2 sho	Completed		autops perfor	sy	prior to completion death?	
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Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate b irs after death.  **I Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the bun	ادہ	25. Was case referred to medical 26.Place of Death (Check	only one)	<b>'</b>		
Vita ysicia direc	TO B	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursin	ng Home 5 I	Residence 6	✔ Other: Scene	
Of ug Ph		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occur	red	
ath.	힐	Natural 5 Pending 1 Yes 2 No				
Division Hospital or Attend 24 hours after death. Funeral Director:	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	treet and Numb	er or Rural Route	Number, City
Div ra after red in	팋	3 Suicide 6 Could not be determined (Specify)	or Town, St	ate)		
lospii 1 hour 1 hour 1 h fill		29a. Certifier	d due to the cause	a(s) and manna	r as stated	
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	at the time, date a	and place, and	due to the cause(s	)
To the within To the comple	Jed	and manner stated.  29b. Signature and title of certifier  29c. License number			ned (Month, Day, Y	
		// 1/3 A DOME		May 25, 20		
		Meadore W. Mad JRy m. d.	CME	iviay 20, 20		
8,1	1	30. Name and address of person who complete occur e) if death (Item 23a)				
Oxtoring	2 3	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 21201			
		31. Date filed (Month, Day, Year)				
Regist	trar	WAY 2 7 2009 Server & parked	_			
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**Physician** /Medical **Examiner** The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

attending physician and for use as the burial-tran signed by the atte To the Hospital or Attending Phystclan: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should

**Funeral** 

Director

show

death with the

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examinations of the mathematic event, the Medical Examinations once.

art II. Other significant conditions con	tributing to death but not resulting in the under one obstants puls	rlying cause given in Part I.		se contribute to the cause of death?
penpherol	Vasculor Diseise		24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause o death? 1 ☐ Yes 2 ☐ Ho
5. Was case referred to medical examiner?	ospital:		eath (Check only one)	
7. Mann of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Getermined	28a. Date of Injury (Month, Day, Year)  28b. Place of Injury - At home, farm, street, building, etc. (Specify)	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury	d Number or Rural Route Number,
	sician: To the best of my knowledge, death or ner: On the basis of examination and/or inves and manner stated.			
9b. Signature and title of certifier	tanusio	29c. License number 0 - 2809 7	29d. Date	e signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 25, 2009 **Physician** 5:32 A M Gladys R. Woo-Lun /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto. Stella Maris Timonium 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or For Country)
September 10,1920 Australia 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min. 1 □ M 2 😾 F 098-24-4922 88 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Tre Medical Exp. in or instituted at once. 1 ☐ Yes 2 ☐ No Director Perry Hall Md. Balto. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21128 5 Brook Farm Ct. Unit B USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 No If Yes, Give A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Asian Specify. Specify 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Typist Pharmaceuticals Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Tye Mabel (Unknown) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Woo-Lun Spouse 5 Brook Farm Ct. Unit B Perry Hall, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 1 ☐ Other (Specify) 5-26-2009 Baltimore City, Md. Bayview 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the children of the Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 □Yes 2 X No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{\subset}\) Nursing Home \(5 \subseteq\) Residence \(6 \)\(\mathbb{X}\) Other (Specify) \(\mathbb{HOSPICE}\) Hospital: 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 K) Natural 5 Pending i 24 hours after death.

e Funeral Director: Af letely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

GLADYS WOO LUN

2009

25,

State Registrar

JACKIE JONES, CRNP 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

oneX Nurse Practitionerner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

within 2

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	ryland /	•	tment of I		and Me		giene , Reg. No. <sup>4</sup>	2009	16916
			Decedent's Name (First, Middle, Last	t)					2	. Date of Dea			3. Time of Death
	Physici		Clementine	Maxzine	2	Wi 1.1	liams		M	ay 21,	200	9 Year	9:45 a.M
	/Medi Examir		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location o				County of Death	
	LAGIIII		Casey House			1	Rockvill	.e			Mo	ntgomer	У
ī	Funeral	1	5. Social Security Number 6. S		(In yrs. last b		If Under 1 Year Months Days	If Under 2	24 Hrs. 8 Min.	Date of Birtl	h v. Year)	Cou	place (State or Foreign
	Director		5/8-56-3156	□ M 2 <b>X</b> ]F	66	Yrs.	Moritins Days	riours	M	(Month, Day ar. 29	, 19	43 (un	kńown)
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	ar Loop	tion				_		10d. Inside City Limits
	aryla shov	5	MD Montgome	rv	German		illon						1 □ Yes 2 No
	he M	Director	10e. Street and Number				10f. Zip Code				10a Citize	en of What Cou	
	a or			Destar			20874					ed Stat	*
	be filed within 72 hours after death with the Maryian that Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	13712 Lark Song	12. Was Decedent E	ver in IIS	13 W/s		Hienanie Orie	nin? /Sneci			4. Race - Amer	
_	item item	Ē	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Y	as Decedent of I (es, specify Cub	an, Mexican	, Puerto Ri	can, etc.)	, I	Black, White	
5	rs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 [	⊒Yes 2. XNo	Specify:			5	Specify: Bla	ck
215-0036	2 hou		15. Decedent's Ed	ucation	16	Sa. Decede	nt's Usual Occu	pation				d of Business/li	
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7	d with giene sr tha	mo.	12	2	· (	Compu	ter Prog	gramer			U.S	. Coast	Guard
פ	othe vent,	Be C	17. Father's Name (First, Middle, Last)							First, Middle,		,	
yland	Aents Aents rked tic ev	To E	Hudson Allen Jac	ckson				Marj	orie	Rebeco	a Fi	elds Bu	ırns
Mary	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.  Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	Γ.	19a. Informant's Name/Relationship (	Type. Print)	19	9b. Mailing	Address (Street	and Numbe	er or Rural i	Route Numbe	er, City or	Town, State, Z	ip Code)
Ξ,	es 1 and 2 of Health of ritem 27 Is rother tra		Sherrie Lynn Wil	lliams (da	ugh)	13712	Lark So	ong Dr	. Ger	mantwo	n, M	D 20874	<b>.</b>
Jre,	of He		20a. Method of Disposition	D	20b. Place ceme	of Disposit	tion (Name of tory or other pla	ce) M	lay 23	e S	20c. Loc	ation - City or T	own, State
aitimor	Pages nent of unt: If its ury or o		1 ☐ Burial 2√☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State			Cremate	i	2009		Belt	sville,	MD
a	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic once.		21. Signature of Funanal Service Licen	see					Rapp	Funera	al &	Cremati	on Service
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			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. D	o not enter	the mode of dyi	ng, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
Q.	Physician	(i)	Immediate Cause (Final disease or condition			sopha	geal Ca	ncer					Onset and Death
	/Medical		resulting in death)	Due to (or as a			0						
	Examiner			h									
	B +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	e of):						25	
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و	ertific ing p as t	Mec	IF FEMALE:										
ŏ Ro R	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗀 Fetal dea		Ectopic pregnan	су			2:	3d. Date of deli Month	very Day Year
5	the a	sici	1 □Yes 2 □No	4 ☐ Pregnant at 9 ☐ Unkn <i>o</i> wn	time of death	1 5□0	Other (specify)					WOTH	Day 10a
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Hecords,	requi	Completed								- '''	65 2	] 140 3 7 7 1	DDADIY 4K OHKIOWI
စ္ခ	The law ate has b page 2 st	P P								24a. Was autop	sv	prior to c	topsy findings available ompletion of cause of
_	: The	S									rmed? 2 ☑No	death? 1 ☐ Yes	2 □No
Vitai	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	112-1-1			Tou			Check only o			
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DIVISION	tend leath tor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be					]Yes 2□I					
≥	or At fter d frec in by	i#	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, . <i>(Specify)</i>	farm, stree	et, factory, office		28	City or Tou	Street and vn, State)	l Number or Hu	ral Route Number,
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	F ≥ F 8		29b. Signature and title of certifier  Jocelyne	Kouest	heil,	mD	20	063	768	, ,		21, 200	
			30. Name and address of person who  Jocelyn Kouatch					arkwa	v. Ba	ltimor	e, M	D 21218	
	C+	ate	31. Date filed (Month, Day, Year)	32. Registra		OHITVE	LUILY I	ar nova	, <b>,</b> 2a		-		
	Pogist		. (80,100)										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04038 State of Maryland / Department of Health and Mental Hygiene Kevin Wright Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month 0912 hrs May 21, 2009 Medias Examiner 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (if not institution, give street and number **Baltimore** St. Agnes Hospital g Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Days Hours Country) Mar Months Feb. 1 2002 Director 214-63 7272 1 - M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No or items 23a or 28a-f show must be notified at once. yaryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 12. Was Decedent Ever in U-S 11. Marikal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married Yes No Yes 2 No specify: more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", of prother traumatic event, the Medical Examiner may other  Medical Examiner may other traumatic event, the Medical Examiner may other traumatic event, the Medical Examiner may of the Widowed Divorced If Yes, Give Year 16b. Kind of Business/Industry ò 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) uden 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Ken2ie Na Be Michae mber, City or Town, State, Zip Code) 21216 (Street and Number of Rural Route 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) ဥ St. Battmore 3012 Brighton Kenzie 20c. Location - City of Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Maryland 2 Cremation 3 Removal from State Burial Cemeter Department o Other Specify permit. 21. Signature of Funeral Service License 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Between Onset and Physician failure. List only one cause on each line. Death **Medical** Complications of gastroenteritis and focal Immediate Cause (Final disease ∡aminer Due to (or as a consequence of): bronchopneumonia or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Division of Vital Records, P.O. Box 68760, 110spital or Attending Physician: The law requires that the death certificate be executed 23a,PII,27,perME, g892 6/19/09 TT Physician/Medical AMENDED attending physician i X UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FFMALE Day Year 23b. Was decedent pregnant in the Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 V Unknown signed b ò Obesity; fatty liver 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? s certificate has be rector, page 2 sh performed' ✓ Yes 2 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other, Nursing Home 5 Residence 6 examiner? Inpatient 2 🗸 ER/Outpatient 3 this No 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? After t funeral 28a. Date of Injury 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No n 24 hours after death.

The Funeral Director: A steely filled in by the fu Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 22, 2009 O.C.M.E 200 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Ling Li, MD

31. Date filed (Month, Day, Year,

Assistant Medical Examiner

32. registrar's Signature

111 Penn Street, Baltimore, MD 21201

# Baltimore Maryland 21215-0036

		•	for State Registrar	State of Mary		Certificate of			1. No. 200	9 16918
	Physici	an	1. Decedent's Name (First, Middle, La				2	2. Date of Death Month	Day Year	3. Time of Death
*	/Medic				NNE			Month 5	25 200	
	Examir	ner	4a. Facility Name (If not institution, giv College Manor Ass		o.a	Luthers	r Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birth	day) If Under 1 Year	If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Y	9. Bi	thplace (State or Foreign
	Director		217-20-1172	⊠ M 2□F 81	Yı	rs. Months Days	Hours Min.	5/27/19		ountry) ryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town	or Location				10d. Inside City Limits
	Maryla f sho	ō	MD Baltimo		imoniu					1 ☐ Yes 2 📉 No
	r 28a	irec	10e. Street and Number		211101720	10f. Zip Code		100	g. Citizen of What C	ountry?
	th with	Funeral Director	5 Gurteen Court	#201		21093		U	J.S.A.	
	tems tems	nuel	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S.	13. Was Decedent of H If Yes, specify Cubi	Hispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi	
36	irs afte	þ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 Mayes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Markent Eventiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	l ducation ade completed)	16a. [	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	pation during most of working	16	6b. Kind of Business	/Industry
121	should be filed within ad Mental Hygiene. marked other than 'matic event, the Me	ldmc	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT use retire. n Financer	d)		Mobile H	Homes
ld 2	il Hygi other	Be C	17. Father's Name (First, Middle, Last,	)			18. Mother's Name (	First, Middle, Ma	aiden Surname)	
/lar	should be f and Mental   s marked of umatic eve	To E	Jesse Wanner				Rosetta B	oyer		
Maryland	. co co		19a. Informent's Name/Relationship (	Type. Print)		Mailing Address (Street				Zip Code)
	l and leal leal m 2		Charlotte Wanner 20a. Method of Disposition			Brandon Re			0c. Location - City o	r Town State
Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specific Control of Con	Removal from State		Disposition (Name of crematory or other place Gifts Registr			Hanover, I	
altii	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licer		* Accessing		ess of Facility Ana		·	
<u> </u>	8 9 E 8 9		1 30150	7		7522 Conn	elley Dr.,	Ste.P,	Hanover,	MD 21076
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.	leath. Do no	t enter the mode of dyi	ng, such as gardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. (on )	estive	e flecu	* Joul	evre		2 days
	Examiner			Due to (or as a goh	sequence of	):	9			5 years
	T -	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a don	sequence of	):				3 400
	rificate be executed ng physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						•
68760,	be ex		a seeming in assum, assume	Due to (or as a con	sequence of	).				
687	ifficate g physas the	Aedical		a						
Вох	attendin for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		3 ☐ Ectopic pregnance	cv		23d. Date of d	
O. E	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown		5 ☐ Other (specify) _	-,		Month	Day Year
<u>o.</u>	that the		Part II. Other significent conditions	contributing to death but not	resulting in t	he underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds	quires n sign ald be	d by	organic	Cernen	tra			1 ☐ Yes	2 <b>№</b> No 3 🗀 I	Probably 4 Unknown
Records,	aw requir as been s 2 should	Completed	0					24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
<u>~</u>	The laste has page	Com						performe	ed? death? □No 1□Ye	127
Vita	Physician: Tribis certificaral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death	(Check only one)	)	
of	Phys r this ral dir	: To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	2 ER/Outp	battent 3 DOA	4 Nursing Hom	e 5 Residen	nce 6 Other (Sp	ecify)
	Attending I ir death. ector: Affer by the funer	Certification:	1 ■ Natural 5 Pending 2 Accident investigatio	(Month, Day, Yea	r) Inj	ury Wor	rk? ]Yes 2 □No	5d. 5 000/150 /10 /1	, injury coournou	
Division	r Attendi er death. rector: A	tifica	3 ☐ Suicide 6 ☐ Could not be determined		At home, farn	n, street, factory, office	21	Bf. Location (Stree	eet and Number or i State)	Rural Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in I		29a. Certifier 1 ☐ Certifying Pl	nysician: To the best of my			ime date and place a	nd due to the ca	use(s) and manner	as stated
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Median Example (Check only one)	miner: On the pasis of exar and mariner stated.	mination and	or investigation, in my	opinion, death occurre	d at the time, dat	te and place, and di	ue to the cause(s)
	To the vithii Comp	Me	29b. Signature and title of certifier	1 Augh		29c. Licens	se number	29	d. Date signed (Moi	nth, Day, Year)
	1		1/1010	1/WW.	(14	V- (	12557	/	way L	6' 2009
	\ V		30. Name and address of person who	completed cause of death	(item 23a) (T	ype Print) L Hamille	ad Sute	222	Brotin	core 21210
	Sta		31. Date filed (Month, Day, Year)	3. Registrar's S	ignature	Saled	2000.00	7.2	Vi vo	
	Registi	ar	MAY 27 200	9 Centra	p. A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

			_	<b>pe or Print i</b> State of Mary							ogibic.	
			1 _ State	State Of Ivial y			of Death	and Me		g. No. 2	009	16919
			Registrar  1. Decedent's Name (First, Middle, Last)					2.	Date of Death	1		3. Time of Death
	Physicia		Lillian Anna Weira	uch				Į,	Month Nav 2	Day	Year 2009	2:50 A <sup>M</sup>
4	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Tov	vn, or Location of				ounty of Death	
			202 D Fairwood Roa				l Air	0411			Harfo	
	Funeral		5. Social Security Number 6. Sex	1 2 3 F	yrs. last birthday) Yrs.	If Under 1 Y Months D	ear If Under ays Hours	Min.	Date of Birth (Month, Day,			place (State or Foreign intry)
	Director		215-24-1275 Usual Residence of Decedent		38			I.V	May 28,	_192	U Ma:	ryland
	ryland how	_	10a. State 10b. County	100	c. City, Town or Lo	cation						10d. Inside City Limits
	the Marylan 28a-f show otified at	Director	Maryland Harfor	d	Bel	Air						1 □Yes 2 XNo
	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Evant without but withed at		10e. Street and Number			10f. Zip Co			10		n of What Cou	intry?
	eath v	Funeral	202 D Fairwood Roa	. Was Decedent Ever	in U.S. 13.1	210 Was Deceden		igin? (Specif	v Yes or No-	USA 14.	. Race - Am <i>e</i> r	ican Indian.
(0	r iten		1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 🔀 No			t of Hispanic Ori Cuban, Mexicar		án, etc.)		Black, White,	
5-0036	ral",o	1 by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2 <b>K</b>	No Specify:			St	pecify: Wh.	ite
5-0	72 hc "natu	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	(Give	dent's Usual C kind of work of	lone durina mos	at of working		16b. Kind	of Business/II	ndustry
2121	filed within Hygiene. Ither than "	Jmp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use r I <b>stress</b>				Clot	hing M	anufacturer
<b>d</b> 2	filed Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)		Sean	suess		er's Name (F	First, Middle, N			anaractarer
<u>lan</u>	Aenta Aenta rked tic ev	To B	Henry J. Horn				Mar	garet	M. Mus	son		
Maryland	d 2 should be filed within 72 hours after death with the Maryla th and Mental Hyglene. 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madeal Exactional Countile of the traumatic event, the Madeal Exactional Countile of the control of the countile of	0 3	19a. Informant's Name/Relationship (Type	. Print)	19b. Mailir	ng Address (S	treet and Numb	er or Rural R	Route Number,	City or T	own, State, Z	ip Code)
2	1 and 2 Health em 27 i		Charles A. Weirauch				est Ct.					The state of the s
altimore,	S to E C	1	20a. Method of Disposition 1 ☑ Buria 2 ☐ Cremation 3 ☐ Per	noval from State	0b. Place of Dispo	natory`or othe	r place) ¦	Date			tion - City or T	
Ē	permit. Page Department Important: If any injury o		4 Donation 5 Dther (Specify		Holly Hil					alti	more, 1	Maryland
Ba	permit. Departr Importa any injt	6 1	21. Signature of Funeral Fe AcerLice Lee	V	_ Mc	Comas 17 Cok	funeral Funeral esbury	"Home, Rd., A	, P.A. Abingdo	n, M	D 2100	9
			23a. Par 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the cause on each line.	death. Do not ent	er the mode o	of dying, such as	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition	META	STATIC	PAN	CREAT	1C (	CANO	ER		MONTHS
4	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):							
		ē	Sequentially list conditions, b.	Due to (or as a ro	verquetire oi):							
	cuted id ansit	Examiner	Sequentially list conditions, and, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
o,	te be executed ysician and e bunal-transit		resulting in death) Last	Due to (or as a co	nsequence of):							
8760,	cate b	dical	d.									
x 68	ding p	/Me	IF FEMALE:	. If yes, outcome of pr	reanancy					T	d D-46 d-15	
Вох	The law requires that the death certificate are been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3	☐ Ectopic preg ☐ Other (speci				230	d. Date of d <i>e</i> li Month	Day Year
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о, С	s that med b	by Pi	Part II. Other significant conditions contr	buting to death but no	t resulting in the u	nderlying caus	e given in Part I	ı.	23e. Did tot	acco use	contribute to	the cause of death?
ğ	w requires been sign should be								1 □ Ye	s 2	No 3□ Pr	obably 4 Unknown
of Vital Records,	law re as be 2 sho	Completed							24a. Was ai		24b. Were au	topsy findings available completion of cause of
<u>=</u>		Con							perform 1 □ Yes 2	ned? No	death? 1 □Yes	2 □ No
Vita	Physician: The	Be	25. Was case referred to medical examiner?	spital:			0.1		Check only on	,		-
5	§ '≅ '§	7.	1 Yes 2 No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpaties 28b. Time o				d. Describe ho			cify)
on	Attending or death. ector: After by the fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Ye	ar) Injury	м	Injury at Work? 1 ☐ Yes 2 ☐		a. Doddino ile	,,		
Division	Atter ar dea ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury		eet, factory, of	ffice	28f	Location (St City or Town		Number or Ru	ral Route Number,
Ö	tal or rs afte al Dir ed in	Certification:	4   Nonlicide	building, etc. (S	pecity)			10	Chy of Town	i, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  Check only one)  Check only 2 Medical Examine									
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. L	icense number		2	9d. Date	signed (Month	n, Day, Year)
			Crais m. Sh	reglino 11	u.D.	0	20750	78	7	Noy	22,2	009
	1 .	Ì	30. Name and addr so of person who com			Print)				J	•	-
	1		Craig Shaughnessy,		4 Plumtr	ee Rd.	, Bel A	ir, MD	21014			
	Sta Registra		31. Date filed (Month) Day, Year)			1	60					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22 Pay Month 20ď9 **Physician** 8:41 PM Thomas Eugene Wilson /Medical 4c. County of Death 4b. City, Town, or Location of Death a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Hospice Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. | Dec 31, | 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Maryland 1 XM 2 □ F 212-40-8356 66 1942 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Exa virus must be retified at 10a State 1 ☐ Yes 2 → No Director Lutherville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number filed within 72 hours after death with 21093 USA 206 Meadowvale Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 XYes 2 No If Yes, Give Year or Dates: 1959–61 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White ğ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medice. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Baltimore City Fire Dept Fire Fighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Virginia Stine Bosley Eugene Wilson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 206 Meadowvale Road Lutherville, MD 21093 Linda L. Kirby/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State W. Arundel Crematory 05/26/09 Odenton, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Color Homes Cremation Service P.O. BOx 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Ponset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed and burial-tran Due to (or as a consequence of) P.O. Box 68760. the attending physician requires that the death certificate be Physician/Medical the as nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 3 ☐ Probably 4 ☐ Unknown 2 🔲 No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗆 No 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 X No 1 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: After 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c.\_License number 29b. Signature and title of certifier

10+1

State Registrar

		State of Maryland /		rtment of Healt tificate of Deat			2 (	nna	16021
	-	Registrar  1. Decedent's Name (First, Middle, Last)	Cer	incate or Deat		2. Date of Death	g. No. 💪 🕻		3. Time of Death
Physic		Deborah	Al	UQDAH		Month	Day	Year 2009	1703PM
/Medi Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locati	ion of Death		4c. County		
		The Johns Hopkins Hospital		Baltimore City					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b)	irthday) Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Y 09/08/	<sup>(ear)</sup> 1951	9. Birthpl Counti New	ace (State or Foreign y) <b>Jersey</b>
and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Toy	vn or Lo	cation				11	Od. Inside City Limits
Maryl -f sho	į	OH Hamilton Cin	cin	nati					1 Yes 2 No
h the or 28a notifi	Director	10e. Street and Number		10f. Zip-Code		100	g. Citizen of \	What Count	ry?
death with the Maryland ems 23a or 28a-f show must be notified at		2177 Crane Ave.		45207			US	A	
_ a # a	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give		Vas Decedent of Hispanion of Yes, specify Cuban, Mex  ☐ Yes 2 ☐ No Specify Cuban	c Origin? (Spec xican, Puerto Ri ecify:	cify Yes or No- ican, etc.)		ce - America ck, White, e	tc.
Z15-UU36 thin 72 hours aft e. an "natural", or Medical Examin	q pe			lent's Usual Occupation		1	6b. Kind of E		ack
in 72 in 72 "nat	pleto	(Specify only highest grade completed)	(Give .	kind of work done during on NOT use retired)	most of working		db. Kind of L	00311633/1116	lustry
Z Figure 4	Completed		dmi	nistrative	e Assi	stant	Univ.	of (	Cincinnati
e de de de de de de de de de de de de de	Be C	17. Father's Name (First, Middle, Last)		18. M	Nother's Name	(First, Middle, M	aiden Surnai	me)	
	2	Charlie Russell				allowa	•		
Mar d 2 sho th and th and 7 is m trauma				g Address (Street and Nu					20020
C = C/2		Shareefah Al'Uqdah/Daughter  20a. Method of Disposition  20b. Place	23	03 Good Ho	ope Ct	Apt.	301, Oc. Location	Wash:	ington DC
Pages nent of lint: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemet	ery, cren	natory or other place)	.1			,	
baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe		4 Donation 5 □ Other (Specify) Geor  21. Signature of Funeral Service Licensee		Wash. Ceme Name and Address of Fa			Adel		mD ry Inc.
Dep Dep and and and and and and and and and and		Kases With		11 Kennedy	J				-
		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure—ist only one cause on each line.	not ente	er the mode of dying, suc	ch as cardiac or	respiratory arres	st,	OIL	Approximate Interval Between
Physician	8 1	Immediate Cause (Final		emia					Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence		CITICE					
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pe pe sit	Examiner	if any, leading to immediate  bue to (or as a consequence cause (Disease or injury	e ot):					-	
xecut and al-trar	Exa	that initiated events c resulting in death) Last Due to (or as a consequence	e of):					-	
<b>6 / 50,</b> cate be executed physician and sthe burial-transit	edical	d							1
tificate g phy as th	Med						-1		
In Records, F.O. BOX 6878  The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	Physician/M	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1	th 3 [	Ectopic pregnancy			100	ite of delive	*
e dea he att hed fo	ysic	1   Yes 2   No 9   Unknown   Unknown	5 🗆	Other (specify)			1010	onth	Day Year
hat the d by th		Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause given in	Part I.	23e. Did toba	acco use con	tribute to th	e cause of death?
aw requires the been signed 2 should be	d by			, 5		1 □ Yes	\/	3 🗌 Proba	
v requ	Completed					24a. Was an	24b.		osy findings available
he lav has age 2	m o					autopsy performed		prior to cor death? 1  Yes	npletion of cause of
	Be C	25. Was case referred to medical		· 26. P	Place of Death (	Check only one)	200	1 163	2 140
yslcie is cert direc	TO B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/O	utpatien	3 DOA Other: 4	Nursing Home	e 5 🗌 Residen	ce 6 🗆 Oth	ner (Specify)	
ng Physter this		27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b.	Time of Injury	28c. Injury at Work?	28	3d. Describe how	v injury occur	rred	
Attending r death. ector: After by the fune	cati	2 Accident investigation		M 1 Yes 2		26.1			/ Do do Aleman
or At after of Direct in by	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide	aiii, Sife	et, factory, office	28	3f. Location (Stre City or Town,		ber or hura	Houte Number,
spltal ours eral		29a. Certifier Certifying Physician: To the best of my knowledg	e, death	occurred at the time, dat	te and place, ar	nd due to the car	use(s) and m	anner as st	ated.
To the Hospital or Attending Physician: Whin 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical	(check only one) 2 ☐ Medical Examiner: On the basis of examination at and manner stated.	nd/or inv	estigation, in my opinion,	, death occurre	d at the time, da	te and place	, and due to	the cause(s)
To th To th	ž	29b. Signature and title of certifier		29c. License numb	per	290	d. Date signe	d (Month, E	ay, Year)
D		yes medical Doct	0	D006	7193		may	7	2009
B,		30. Name and address of person who completed cause of death (Item 23a)	) (Type,	Print)	600 1	orth Malf	J - D-	ıltima-	0 MD 21207
Sta	to	PMU E De Ze ()  31 Manage (iled (Medita, Ray Year) 32. Regintrar's Signature			OUU N	OFUI WOIT	e oi, Ba	illimor	e, MD, 21287
Regist		31 Ray (Medity Ray Year)  32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 32 (M **Physician** HARLE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 506 Lethbridge Ct. Millersville Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country)
 VA Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 3/30/1931 1 XM 2 □ F 223-36-5472 78 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10a State 10c. City, Town or Location nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arthment of Health and Mental Hygiene.

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, Ith Avadical Evantination and the motified at 1 ☐ Yes 2 No Director M Millersville Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21108 USA 506 Lethbridge CT. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1949 Saltimore, Maryland 21215-0036 1 ☐ Yes 2√√No If Yes, Give Year or Dates Specify. White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Maintenance United Airlines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Charles Allen Inez Elizabeth Otis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 506 Lethbridge Ct. Millersville, Md 21108 Denise Allen Executrix 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or Maryland Veterans Cem 5/11/2009 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funera ali 12 Ridgely Ave. Annapolis, Md 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a con vuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician the detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Partl. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🗌 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No nent 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, p 25. Was case ref rred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29a. Certifier

(Check only one)

29b. Signature and title of cartific

Name and address of person

Medical

31. Date filed (Month, Day, Year) MAY 11

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Prin

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

76, 4 WA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) May 6, 2009 **Physician** Marsha K. Adams 23:57 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖵 F 127 40 4651 59 23,1949 Director Baltimore.MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examination and the notified at 1 □Yes 2 □No Director Maryland Montgomery Silver Springs 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 733 Sligo Ave Apt 109 20910 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black White etc 1 □Yes v2 v No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√No Specify: Specify: ð X Widowed 4 ☐ Divorced Black Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otis Lanikins Shirley Lee Barksdale 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretha Banks- Wallace (Daughter) 142-19 168th St. Jamaica, NY 11434 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Carmel Cemetery 5/20/2009 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of Important: If it any injury or o once. Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sen 22. Name and Address of Facility Roger J. Mason Funeral Service ice Liden or 5801 Cleveland Ave, Riverdale, MD 20737 23a. Part 1. En er the ease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock heart Mure. List only one cause on each line Immediate ause al disease o condition resulting in death **Physician** Septicemia /Medical Due to (or as a consequence of) Examiner Endocarditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit End Stage Renal Disease Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 H Unknown has been si e 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 1 No page certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 🕅 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury within 24 hours aner ....
To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🖄 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Atul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Katyaz MD.

27 2009

DHMH 17 Rev 1/2001

1)

29c. License number

D0061652

Suite 101 6 Post Office Rd Waldorf Md 20602

29d. Date signed (Month, Day, Year)

009

Bou

Certificate of Death

4b. City, Town, or Location of Death

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Edward Rogers,

MD

gegistrar's Signatu

3. Time of Death 10:23 A M

9. Birthplace (State or Foreign

10d. Inside City Limits 1XYes 2 No

Approximate Interval Between Onset and Death

6 months

Washington, DC

Reg. No.

2009

1957

4c. County of Death

Montgomery

14. Race - American Indian.

Specify: White

Development

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

May 8, 2009

2. Date of Death

Month May 7,

**Physician** /Medical

Examiner

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Edward

Christopher

DHMH 17 Rev 1/2001

State Registrar

D50030

5530 Wisconsin Ave. #1400 Chevy Chase, MD 20815

871

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark Parkhurst, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Bisesi Mary Jane 2009 1:00A May 8, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville Rockville Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/7/1925 Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 □ M 2X F NY Syracuse, 83 132-14-9400 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 United States 303 Adclare Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be "unknown" Maria Salvatore Cacciola ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6884 Thomas Drive Liverpool NY 13088 Francis A. Bisesi - Son 20b. Place of Disposition (Name of cametery, orematory or other place.
St Mary's Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 5/15/09 Dewitt, NY 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 M01163 21. Signature of Funeral So vice License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease Immediate Cause (Final erebrorasco (cr **Physician** resulting in death) Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to miniociate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alzheiners 2 No 3 Probably 4 dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 🔲 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State

DHMH 17 Rev 1/2001

Registrar

29b, Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARMA

29c. License number

29d. Date signed (Month, Day, Year)

D0064624 May 08,2009

Summer Walk Dr. Gaithersburg, MD 20878

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year O 9

5: 30 PM

BALEKJIAN

Physician
/Medical
Examine
Funeral

1 - For State Registrar

BER JOUHIE

4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MONTGOMER SILVER SPRING GENESIS LAYHILL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1 □ M 2 🗗 F Months Days Hours 216-50-6608 75 Director 25. Egypt Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or tems 23a or 28a-f show any Injury or other traumatic event, it. Medical Examinations to a ruffied at once. Quee. 1 ☐ Yes 2 ☑ No Directo Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 USA 5811 Ipswich Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: <u>م</u> 3 Midowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zarouhie Aroutian Stepan Basmajian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4009 Decatur Avenue, Kensington, MD 20895 Hagop Balekjian/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 14 2009 4 Donation 5 Dother (Specify) Silver Spring, Maryland 21. Signame of Funeral Service Linguises Francis J. Collins Funeral Home Inc. Tychard L Dalio 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Demenle disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE use yes, outcome of pregnancy

Live birth 2 ☐ Fetal death

Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 ☐ Other (specify) 9 ☐ Unknown the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy certificate 1 □ Yes 2 **5** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending 24 hours after death. e Funeral Director: A 1 ☐Yes 2 ☐ No investigation the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Pri 20906 State

Registrar

P.O. Box 68760

Division of Vital Records.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 0415 P M 2009 MAY 7 SHIRLEY ANN BAYNARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON TALBOT HOSPICE HOUSE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 XX JULY 31, 1946 62 MD 217-44-2235 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" ~ : any injury or other traumatic everal. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes XX No Funeral Director TALBOT TRAPPE MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21673 4635 OCEAN GATEWAY Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 If Yes, Give Year or Dates: 2**XX**Vo 1 Never Married Married Specify: WHITE 1 ☐ Yes XXNo Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELLEN MAE KENNEDY EUGENE HENRY MURRAY ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) TRAPPE, MD 21673 HUSBAND PO BOX 93 F. LEROY BAYNARD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State MAY 12, 2009 4 ☐ Donation 5 ☐ Other (Specify) WHITEMARSH CEMETERY TRAPPE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part 1. Enfer the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 1 cours **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to financial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cries a consequence of) Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending pt IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a detached f 9 Unknown ισαιε nas been signed l , page 2 should be detε 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform The certificate | 2 🗆 No 2 1 No 1 Yes 1 ☐ Yes Division of Vital Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 to ther (Specify) 1 ☐ Yes 2 N6 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier MJ) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Inwood Dr. Easton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 112009 Registrar

DHMH 17 Rev 1/2001

State of Maryland	Department of	Health and	Mental Hygiene
	•		

Robert Louis Bol		ush Sta	ate of Maryland		rtment of tificate of		and	Menta	al Hyg			2.0	100 100	
Physicia	_	<mark>legistrar</mark> 1. Decedent's Name (First, Middle	e,Last)		inicate or	Death			2.	Date of Dea	leg. No. ath		3. Time of Death	
Medical Exami	ner	Robert Louis Bohorfoush Month May 5, 2009 May 5, 2009					009	Year	0054 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 5717 Greenbelt Metro Drive Greenbelt						ounty of Deal ce Georg						
Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. la	ist birthday)	If Under	1 Year	_	_	8. Date of Bi	rth (MM/DD/	YYYY) 9. B	irthplace (State or Foreign	
Director		229-76-6526	1 X M 2 F	44	Yrs.	Months	Days	Hours	Min.	3-19-	1965	V:	ountry) irginiə	
>-	-	Usual Residence of Decedent 10a, State 10b, County		Ino City	Town or Locati	200							10d. Inside City Limits	
Ow any		Maryland Howard	d		mbia	OII							1 Yes 2 X No	
Maryland 28a-f show datonce.	황	10e. Street and Number				10f. Zip C	ode	_		1	10g. Citizen	of What Co		
rith the Maryland 1.23a or 28a-f shov notified at once.	Director	6428 Quiet Nigl	nt Ride			2104	44				Unite	d Stai	tes	
with ms 23.	eral	11. Marital Status	12. Was Decede			s Decedent es, specify				cify Yes or N	0- 14.	Race - Ame White, etc.	erican Indian, Black,	
r death w or items	Funeral	1 Never Married 2 X M	1 Yes	2 X No					donto ra	0.0.7				
rs afte ura!",	ò	3 Widowed 4 Div	orced or Dates: cify only highest grade of	completed)	16a. Deceden	Yes 2 \sumber 1 \frac{1}{2}			nd of wo	rk done		ecify: [	Nhite s/Industry	
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3036 within iene. er tha	E E	· ·	1-	4	Accour	itant						vate		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Walter L. Bobon								First, Middle, Dyson	Maiden Sur	rname)		
212 ruld be Menta mark	10 B	19a. Informant's Name/Relations	,		19b. Mailing	Address				J	mber, City o	or Town, Sta	te, Zip Code)	
MD d 2 sho lith and m 27 is	. [	Walter L. Bohon	foush, Sr.	(fath	e <b>t</b> ) 1133	31 Mor	ntgo	mery	Road	d Belt	svill	e, Mai	cyland 20705	
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland not of Health and Maryland short of Health and Maryland of Health and Maryland in the Maryland in the Maryland short fraumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 Burial 2 X Cremation	Removal from	State 20b. F	Place of Dispos crematory or other	ition (Name ner place)	of ceme	etery,	- 1- 1	Date			or Town, State	
altimore, mit. Pages I ar ppartment of He. pportant: If ite		1 Burial 2 X Cremation 4 Donation 5 Other Sa	pecify:	Met	ropolit	en Cr	ema	tory	0/6/2	2009			ia, Virginia	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Service  Lawld / /3 23a. Part I. Enter the disease, or	Licensee	4	<sup>2</sup> Dc	iame and A	daress o	Borgy Borgy	vərdi	t Fune	rəl H	ome, I	PA 1 1 2070	
Physician		23a. Part I. Enter the disease, or	complications that caus	sed the death.	. Do not enter the	ne mode of	dying, s	uch as car	rdiac or r	espiratory a	rest, shock,	or heart	Approximate Interval	
'Medical aminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Between Onset and Death  Due to (or as a consequence of):												
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	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence o	f):									
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D, be exe sician	edical	UNPENDED	AMENDED											
6876( certificate nding physe as the b	ΣI	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, out	_		tal death	3	Ectopic	pregnan	су		Date of delive onth	ery Day Year	
, P.O. Box 6876 ires that the death certificate signed by the attending phy be detached for use as the b	sicia	past 12 months?  1 Yes 2 No 9 Uni	4 Pregnan	t at time of de	-41-	her (Speci	fy)				ļ			
. Box the death c y the atten	Phys	Part II. Other significant condit	9 Ulikilowi		esulting in the I	ınderlyina c	ause di	ven in Par	t I.	23e. Did	tobacco use	e contribute	to the cause of death?	
P.O.	ρ	Tare II. Other Organical Contact	contains to de	cath bat not n	country in the c	indonying c	Judoo g.				-	2 ✓ No 3 Probably 4 Unknown		
ds, require been si	Completed									24a. Wa	s an		autopsy findings available o completion of cause of	
tal Records.	dmo		<del></del>							per	formed?	death'	?	
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Vita hysicia this ce	9	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inp	atient 2	ER/Outpatient					Home 5		e 6 🗸 Ott	ner; Scene	
Division of Vital Records, at an or Attending Physician: The law requires after death an Director. After this certificate has been sited in by the funeral director, page 2 should the	on: T	27. Manner of Death  1 Natural 5 Pene	28a. Date of (Month, D.) May 5, 200	Injury av Year) )9	28b. Time of 6 0000 hrs	njury 28		at Work? es 2 ✔	ls.	28d. Describe Subject ha				
ivisior or Attend after death Director:	icati	2 Accident Inve	stigation 28e Place of	of Injury - At h	ome, farm, stre	et, factory,				28f. Location	(Street and	Number or	Rural Route Number, City	
O Light of the control of the contro							or Town, State) 17 Greenbelt Metro Drive, Greenbelt, MD							
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t		29a. Certifier 1 Certifying P (Check only one) Medical Exa	hysician: To the best o	ian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  r:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
To wit	Medical	29b. Signature and title of certific	and manner stat	ed				number					Month, Day, Year)	
20		WING	~		2 MD		O.C.N	1.E.			May 5	5, 2009		
		39. Name and address of person	/		n 23a)		1 ·	Deli		04004	<u> </u>			
		Russell Alexander ME		dical Exan		Penn S	treet,	Baitimo	re, MD	21201				
Regis	tate trar	31. Date filed (Month, Day, Yoar)	2009 Ceneu	400	frank	2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 2009 **Physician** May 4, 1150A Julius Babiskin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/08/1923 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) Sex 1 M M 2 □ F **Funeral** 86 067-14-5105 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show other traumatic event, the Medical Exeminer must be notified at 1X Yes 2 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 11179 Columbia Pike 20901 United States 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No WW ] Pages 1 and 2 should be filed within 72 hours after 2 No WW II 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 ō 1 □Yes 2 X No Specify: White If Yes, Give Year or Dates: Specify. Completed by 3 X Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) US Government Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F is marked otl Dora Solomon Morris Babiskin မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Babiskin - Son 306 Lisa Oaks Way Rockville MD 20850 item 27 i Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any Injury or ot once. 1X Burial 2 ☐ Cremation 3 X Removal from State King David Mem. Grdns 5/7/2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee MO1163 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiac Arrest **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Pancreatic Cancer cate has b page 2 sh certificate 1 □ Yes 2**X** No 1 ☐ Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

P.O. Box 68760, Division of Vital Records, ours after death.

neral Director: Af To the Hospital o within 24 hours aff To the Funeral DI completely filled in

> State Registrar

Medical

(Check only one)

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harold Vincent Lawson JR MD 1500 Forest Glen Road Silver Spring MD 20910

31. Date filed (Month, Day, Year)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D67589

29c. License number

29d. Date signed (Month, Day, Year)

May 6, 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month 5/6/2009 915pm M Oscar E. Billingsley 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Spa Creek Date of Birth (Month, Day, Year) 7/2/1919 Birthplace (State or Foreign Country) AR 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Hours Months Days XXM 2□ F 439-56-8400 89 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Annapolis Anne Arundel ITTYES 28 No 10g. Citizen of What Country? 10e Street and Number 10f, Zip Code 21403 USA 1164 Mainsail Dr. 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No WWII IYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2X Married White 1 ☐ Yes 2€No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Navy Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oscar Elmore Billingsley Ollie Jett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son Daniel Billingsley 1164 Mainsail Dr. Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/25/2009 Arlington, VA Arlington National 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hardesty Funeral Home, Annapolis, MD 21401 12 Ridgely Ave. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 50 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 ⊡√No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No

Physician /Medical Examiner

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr

**Physician** 

/Medical

Examiner

10a State

MD

**Funeral** 

Director

ms 23a or 28a-f show must be notified at

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items traumatic event, the Medical Examiner m

Examiner

burial-tran attending physician for use as the buria Physician/Medical ate has been signed by the page 2 should be detached ģ Completed director, Be Certification: To funeral

b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

9 Unknown

29a. Certifier

(Check only one)

1 ☐ Yes 26. Place of Death (Check only one)

25. Was case referred to medical examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2. TÑo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred

27, Manner of Death 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

33036

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 805 50

and manner stated.

orah Dr. we Chite.

State Registrar

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within 2 To the I

filled in by

Medical

State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death

**Physician** /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item s 23a or 28a-f show any Injury or other traumatic event, it a Medical Examinar must be profilled at

21215-0036

Maryland

Baltimore,

**Physician** /Medical **Examiner** 

and burial-trar burs after death. eral Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for u

or Attending Physician: The law requires that the death certificate be executed

Box 68760.

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Records,

of Vital

Division

Hospital within 24 hours a

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year MAE BAKER LISA 9:40 A M MAY 8 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frederick Kline Hospice House Frederick 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Hours Min Months Days 214-80-0366 49 July 17 1959 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Md. Frederick Mount Airy 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12555 Quiet Stream Court 21771 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2. No Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rehabilitation 12 Office Manager O 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Audrey Leona Germon, Sr. Helbert Joseph Niles ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12555 Quiet Stream Court, Mount Airy, Md. 21771 Brian Franklin Baker/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/13/09 4 Dopetton 5 Other (Specify) Parklawn Cemetery Rockville, Md. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service License m-004110 P. O. Box 5038, Laytonsville, Md. 20882 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shy k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme vate Cause (Final disease or condition resulting in death) Due to (or as a sonsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ № 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL ST. BAUTIMORE EDAKI S 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

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			For State Registrar		State of M	arylan		artmer <i>rtifica</i> :			Mental Hy	/gieno Reg. No	0000		C D 2 1
				ne (First, Middle, La	nst)						2. Date of D	eath		3. Time	of Death
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	/Medic Examin			(If not institution, gi	ve street and number)	)		4b. City	Town, or	Location of Dea	th	40	c. County of Death	J-,	
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П	Funeral		5. Social Security I		Sex 7. Ag 1 □ M 2 T X F		la <i>st birthday,</i> Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hrs Hours Min	. (Month, D	ay, Year	Cou	ntry)	te or Foreign
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	/land		10a. State	10b. County		10c. Cit	y, Town or L	ocation						0d. Inside	City Limits
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i	items	nue	11. Marital Status		12. Was Decedent Armed Forces?	?	S. 13.	Was Dece If Yes, spe	dent of H cify Cuba	ispanic Origin? ( ın, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	<ol> <li>Race - Ameri Black, White,</li> </ol>		1
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Mar	d 2 Sr th an 17 is r traur			Name/Relationship									or Town, State, Zi	) Coae)	
ຍົ.	Heal Heal tem 2		20a. Method of Dis	rince-Sis	ter	20b. F	Place of Disponentery, cre			1 Lane	Date	<del></del>	N. 38018 Location - City or To	own, State	,
baltimore	permit. Fages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Fages 1 and 2 should be filed within 4 hours after the face of the marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a martical Examinat must be notified at once.			☐ Cremation 3 ☐ 5 ☐ Other (Special	Removal from State					ery 5-8	2000	Sui	tland, M	d	
	oortar Sortar			uneral Service Lice	-	1111	2	2. Name a	nd Addre	ss of Facility				4.	
Ď	Depar Impor any Ir		Nec	WE-W	<i>l</i> <i>D</i> erek	: S100	cum 4	arsha 308 S	ıll's uit1	Funeral	L Home o Suitla:	i Ma nd.	ryland $Md \cdot 20740$	5	
					oplications that cause	d the deat	h. Do not en	ter the mo	de of dyir	g, such as cardia	ac or respiratory	arrest,		Approxin	Between
. P	hysician		Immediate Cause disease or conditi	(Final	Ather	25cl	erot	ic (	ard.	POVASCU	Par H.	Carp	T Dise	Onset ar	nd Death
	/Medical		resulting in death)	•	Due to (or as	a conseq	uence of):								
ľ	.xammei	J.	Sequentially list co if any, leading to in	onditions,	b	2 2 2 2 2 2 2 2	uence of:								
1	nsit	nine	Cause. Enter Und Cause (Disease o	erlying r injury	Due to (or as	a conseq	derice or).								
,	be executed cian and ourial-transit	Examiner	that initiated event resulting in death)	tş 🔛	C Due to (or as	a conseq	uence of):								
				•	<b>∟</b> d										
records, P.O. DOX 007	ng ph	Physician/Medical	IF FEMALE:												
XOC T	ttendi or use	ian/I	23b. Was deceder		23c. If yes, outcome 1 ☐ Live birth	2 Feta	I death 3	☐ Ectopic		y			23d. Date of deliver Month	ery Day	Year
5	the a	/sic	1 ☐ Yes 2 9 ☐ Unknow	■No	4 ☐ Pregnant a 9 ☐ Unknown	at time of c	teath 5	Other (s	pecify) _				W.G.	Day	1041
Ŀ	ed by detac				contributing to death t	out not resi	ulting in the u	inderlying	cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause	of death?
cords,	ulles sign Id be	d by		Lung	Dise	452					1 🗆	Yes 2	2 □ No 3 □ Pro	bably 41	Onknown
5	s beer shou	Completed									24a. Wa	s an	24b. Were aut	opsy fi <b>nd</b> in	ıgs available
ב ב	te has	шо									per	opsy formed?	prior to co	ompletion of	of cause of
יונפו	all.	Be C	25. Was case refe	erred to medical						26. Place of De	1 ☐ Yes eath <i>(Ch</i> eck only		o 1 □Yes	2 □ No	
> }	is cel direc		examine	□No	Hospital: 1 ☐ Inpati	ient 2 🗌	ER/Outpatie	nt 3 🗆 D	OA Oth	or:		_	6 ☐ Other (Spec	ify)	
O 8	fter th	L:uc	27. Manner of Dea	th 5 Pending	28a. Date of Inju	ury ay, Ye <i>ar)</i>	28b. Time o	of	28c. Injur Worl	y at k?	28d. Describe	how inju	ury occurred		
11015	eath. tor: A	cati	2 ☐ Accident	investigatio				М		Yes 2 □ No					
	ifter d Direct in by	Certification: To	4 ☐ Homicide	determined		jury - At ho tc. <i>(Specit</i>	ome, farm, st <i>y)</i>	reet, factor	y, office		28f. Location City or To	(Street a wn, Sta	and Number or Rui te)	al Route N	lumber,
	within 24 hours after death,  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier	1☐ Certifying P	hysician: To the best	of my kno	wledge, dea	th occurre	at the ti	me, date and pla	ce, and due to th	e cause(	(s) and manner as	stated.	
3	in 24 h he Fur pletely	Medical	(Check only one)	2 Medical Exa	miner: On the basis of and manner st		ation and/or i	nvestigatio	n, in my c	pinion, death occ	curred at the time	e, date a	nd place, and due	o the caus	ie(s)
ļ	To th	Ž	29b. Signature and	d title of certifier	10	0		29	c. Licens	e number		29d. D	ate signed (Month	Day, Year	r)
	2		1/2	assla	1/1/2	3/2	100		Ho	2559	27	n	17/2	009	,
	En		30. Name and add	tress of person who	completed cause of	death (Iten	n 23a) (Type	Print)	0	ine 1	6	1	h	0	1
	AFX. Sta	te	31. Date filed (Moi	nth, Day, Year	32. Regist	rar's Signa	iture	in	0//		reve	Till I	Man	y an	
	Registr		MAY 1	3 2009 2	Enera 1,0.	10	we								

09-03880 Steven Michael B			<b>Are Legi</b> giene	ble.	10 100			
DI	_	For State edistrar Decedent's Name (First, Middle,Last)	Reg. . Date of Death		3. Time of Death			
Physiciai Medical Examin	er	STEPHEN MICHAEL BLEVINS	Month D May 15, 200		1748 hrs			
		ia. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  16 Howell Point Road  Betterton		4c. County of Death Kent				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth Dec. 25	(MM/DD/YYYY) 9. Birth Foreign Coul	Delaware			
any	F	Jsual Residence of Decedent  0a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
<b>*</b>	اي	MD Kent Betterton			1 X Yes 2 No			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 16 Howell Point Rd. 21610	"	J.S.A.	ry?			
act with the Ma items 23a or 28	= 1	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Armed Forces? If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- tican, etc.)	14. Race - Americ White, etc.	an Indian, Black,			
ter deatl		Never Married 2 Minarried 1 Yes 2 X No 1 Yes 2 X No specify:		Specify: Win	ite			
ours af	g b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of wording life. DO NOT use retire		16b. Kind of Business/In	ndustry			
36 uin 72 h i. i.han "n dical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Grounds Maintenance		Private Co	ollege			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	aiden Surname) SURE							
212 ould by d Ment s mark	To Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Ru			Zip Code)			
MD and 2 sho salth and 2 sho sm 27 is raumat		Tracie Blevins (wife) P.O. Box 52 Betterto  20a. Method of Disposition (Name of cemetery,		20c. Location - City or	Town, State			
altimore, mit. Pages I an epartment of Hea portant: If iter jury or other tr.	I	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 5/2	20/09	Still Pond	d, MD.			
Balti permit. Departm Imports injury o		21. Signature of Funeral Survey Licen ee  M00510  M00510  22. Name and Address of Facility Galena Funeral Hon T18 West Cross St.		ephen 2163				
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.		st, shock, or heart	Approximate Interval Between Onset and Death			
kaminer		Immediate duse (Final disease or condition resulting in death)  a Atherosclerotic cardiovascular disease Due to (or as a consequence of):	se					
	Ļ	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):						
	Examine	cause. Enter Underlying Lause (Disease or injury that initiated						
ted Insit		events resulting in death) Last Due to (or as a consequence or):						
X AMENDED #1 as noted, 23a,27,permE, g893 7/6/09 TT								
tal Records, P.O. Box 68760,  cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transi	ysician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify) 9 Unknown		1	Day Year			
P.O. E	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to 2 No 3 Prot				
tal Records, cian: The law require certificate has been si	Completed		24a. Was a autops perfor	sy prior to o med? death?	utopsy findings available completion of cause of es 2 No			
25. Was case referred to medical examiner?   Hospital: 4   Inacticate 2   EP/Outpatient 3   DOA   Other   Nursing Home 5   Residence 6   Other: Scene								

Division of Vital R
To the Hospital or Attending Physician: 1
within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director.

Other, Nursing Home 5 Residence 6 🗸 Other; Scene ER/Outpatient 3

Hospital: 1 Inpatient 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc.

determined Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie May 16, 2009 O.C.M.E.

ente 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner

Pending

Investigation

Could not be

111 Penn Street, Baltimore, MD 21201

31. Date filed (Moritif, Day, Year) State Registrar

Medical Certification: To

2

3

1 🗸 Yes

27. Manner of Death

Natural

Accident

Suicide

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perfH, 6892, 6/29/09, WS

For AMEND#16aperfH, 5/19/09, EM, Moore State of Maryland / Department of Health and Mental Hygiene

1 - Registrar AMEND#8&10f, perfH, 5/12/09, DFS, Moore Certificate of Death

Reg. No. Day 2. Date of Death 1. Decedent's Name (First, Middle, Last) 4, 2009 **Physician** 6:10a M Cunningham Wayman Bush May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 26 Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Year) 1927 Months **PCX**M 2□ F Kentucky 578 - 38 - 0491 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the "Medical Eventine" oust be notified at Columbia 1 Yes 2 No MD Howard Director 10g. Citizen of What Country? 10e. Street and Number United States -21046 210.46 9404 Slow Rain Way Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 72 hours after 1½ Yes 2 No. 1950-If Yes, Give 1952 Year or Dates: 1952 1 Never Married 21 Married Black 1 ☐ Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Psychologist Clinical Psychotass College (1-4or 5+) Elementary/Secondary (0-12) Psychology Hygiene. d 2 should be filed w. th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Coleman Cunringham Finley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sinent of Health an ant: If item 27 is Way, Columbia, MD 21046 9404 Slow Rain Lillian Veronica Cunningham Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harrodsburg, KY 4 ☐ Donation 5 ☐ Other (Specify) Maple Grove Cemetery May 14,2009 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Fuheral Service Ligensee 36 7400 Georgia Avenue, NW, Washington DC 20012 Condre ) hompson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Parkinson's Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonía Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): ed by the attending physician detached for use as the burial 8 Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown COPD, GERD, Type 2 DM, C. diff colitis Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Attending Physician; The certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Marient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) determined filled in by 4 Homicide thin 24 hours a Hospital Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 D0065 485 Rom.

0

with

death

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/2001

1500 Forest Glen, Rd, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Barbara Supanich, MD

			State of		rtment of Health and N tificate of Death		0000	10000
			Registrar  1. Decedent's Name (First, Middle, Last)		incate of beating	Reg. N	.2009	3. Time of Death
	Physici	an	Joseph Daniel Coury			May 10, 2	2009 Year	1:40 &
	/Medic Examin		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or Location of Death	4	c. County of Death	
<i>)</i> !	Examin	iei	Holy Cross Hospital		Silver Spring		Montgo	merv
Ī	Funeral	1	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Silver Spring If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year July 14,	9. Birthol	ace (State or Foreign
	Director		108-14-4037	95 Yrs.		July 14,	1913 Tex	as
	and w		Usual Residence of Decedent  10a, State 10b. County	10c. City, Town or Lo	cation		10	Od. Inside City Limits
	Aaryk f sho	ō	Maryland Montgomery	Whea	iton			1 ∐Yes 2 ZNo
	the 1	rec	10e. Street and Number		10f. Zip Code	10g. C	itizen of What Coun	try?
	3a ol	<u>=</u>	2821 Parker Court		20902	τ	JSA	
	be flied within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, it is wider Experient must be notified at	Funeral Director	11. Marital Status 12. Was Dece Armed For	dent Ever in U.S. 13. \ces?	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	
õ	after or ite		1 ☐ Never Married 2 【 Married 1 ☐ Yes If Yes. Giv	2 🔀 No e	I∐Yes 2⊠ No <i>Specify</i> :		Specify: Wh	ite
Š	hours ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Da		dent's Usual Occupation	16b.	Kind of Business/Inc	dustry
215-0036	n 72 "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done during most of work DO NOT use retired)			,
717	withi	E O	Elementary/Secondary (0-12) College (1-		aftsman	De	partment	of Defense
פ	other /ent,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maide	en Surname)	
yland		To E	Simon Coury		Elson Ass	ad		
Mar	s 1 and 2 should f Health and Mei item 27 is marke other traumatic	li j	19a. Informant's Name/Relationship (Type. Print) Ethel J. Coury/Wife		ng Address <i>(Street and Number or Ru.</i> Parker Court, Whe			Code)
	s 1 and 2 of Health item 27 other tr	l l					Location - City or To	wn State
<u>0</u>	Pages 1 nent of P ant: If ite ury or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from S	State	natory or other place)	May 13,	•	
altimore,	it. Pa rtmer rtant: olury	1	4 □ Donation 5 □ Other (Specify)		Heaven Cemetery  2. Name and Address of Facility	2009   Si	lver Spri	.ng, MD
a C	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee	F	rancis J. Collins	Funeral H	Home Inc. Lver Sprin	a, MD 20901
			23a. Part 1. Enter the disease, or complications that controls shock, or heart failure. List only one cause on experience of the shock	aused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition Pneu	monia				Oliset and Death
	/Medical Examiner		resulting in death)  Due to (	or as a consequence of):				\
	Examine	<u>.</u>	Sequentially list conditions, b. Deme	ntia or as a consequence of):				}
	ted nsit	Examine	Cause (Disease or injury					
	execu n and al-tra	Exal	that initiated events c.	or as a consequence of):				
8760	ficate be executed physician and s the burial-transit	dical	d					
9	certifica nding phy use as th	ledi	15 FF1111 F		-		-	
Box	leath certific attending p for use as	Physician/Me	23b. was decedent pregnant	come of pregnancy oirth 2 ☐ Fetal death 3 [	☐ Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
о Ш	e death the atten	Sici	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		Other (specify)			
	that the de ned by the a detached to	P.	Part II. Other significant conditions contributing to de	eath but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
Records,	8 56	l by	, art in Casa significant and a same and a same and a same and a same and a same a same and a same same			1 □ Yes	2 No 3 Pro	bably 4 🔀 Unknown
Ö	w require s been si should b	etec				24a. Was an	24b. Were auto	opsy findings available
Ä	The law cate has page 2 s	Completed				autopsy performed	? death?	ompletion of cause of
			25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 🛣	No 1 □Yes	2 🗆 NO
	ysician: is certific director,	o Be	examiner?	npatient 2 ☐ ER/Outpatie	Othor	lome 5 ☐ Residence	6 ☐ Other (Speci	fy)
0	ding Phys h. After this funeral di	Ë	27. Manner of Death 28a. Date (Mon	of Injury 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe how in	njury occurred	
Ö	vttendin death. ctor: Af y the fur	atio	2 Accident investigation		M 1 □Yes 2 □No			
Division of	- b 0 0	Certification: T	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildi	of Injury - At home, farm, st ng, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
_	To the Hospital or within 24 hours aft To the Funeral Dii completely filled in		29a. Certifier (Check only 2 Medical Examiner: On the b	best of my knowledge, dear	th occurred at the time, date and place	i e, and due to the caus arred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	the H nin 24 the Fi	Medical	one) and man	ner stated.				
	Vilt Con	Ž	29b. Signature and title of certifier	11 - 45	29c. License number D22990		Date signed (Month)	
	10		The off (OC	11			-	
	, –		30. Name and address of person who completed cause Lee Edward Schwab, MD		Print) Glen Road, Silve:	r Spring, M	D 20902	
	St	ate	31 Date filed (Month, Day, Year) 32. F	gistrar's Signature				
	Regist		MAY 12 2009	Ereva D. L.	and			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 5 2009 Physician Mav Helen Jane Clark 7:10P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Renaissance Gardens at Riderwood Village Silver Spring Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) Year Aug • 6, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ▼F Months Washington, DC 5**7**9**-**34**-**2352 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Modical Examiner in ust be netitied at once. 1 ☐ Yes 2 XNo Maryland Prince George's Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3158 Gracefield Road, #FC417 20904 United States Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (9-12) Receptionist Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wallace C. Hill Mary Newton ပ 19a. Informant's Name/Relationship (Type. Print)
Marcia J. Clark -daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18004 Vintage River Terrace Olney, Maryland 20832 Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 5/6/2009 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Left Basal Ganglion Intracerebral **Physician** /Medical Due to (or as a consequence of) Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ful as a consequence of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) signed by the a I be detached f Division of Vital Records, P.O. 9 Ulnknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? V. 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 28d. Describe how injury occurred 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the course of t 29a. Certifier cal occurred at the time, date and p (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

3110 Gracefield Road Silver Spring, Maryland 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Wendy DeSilva-Wong
31. Date filed-(Month, Day, Year)

		For	e Type or Prir State of Ma				<b>c. Ensure A</b> Health and	-		_	
Physici /Medic		1 - State Registrar 1. Decedent's Name (First, Middle, I Helen CORNELIU	,		Cei	rtificate of	Death	2. Date of De Month	2. Date of Death Month Day Year  5:50		
Examin Funeral Director	ier	4a. Facility Name (If not institution, 9 Washington Count  5. Social Security Number 6 216–12–7281  Usual Residence of Decedent	y Hospital		a <i>st birthday)</i> Yrs.			,	rth av, Year)	Washing 9. Birth Cou Mar	
ith the Maryland or 28a-f show	Director	10a. State 10b. County  Maryland Washin  10e. Street and Number		· '	Hager				10g. Cit	tizen of What Cou	10d. Inside City Limits 1 □Yes 2 ☑ No intry?
Deficiency in Mary jain 4 12 13-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is investigated at once.	by Funeral	20014 Rosebank  11. Marital Status  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces?			217 Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)		JSA  14. Race - Ameri Black, White,  Specify: wh	
d Z I Z I 3-C	e Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) unknown  17. Father's Name (First, Middle, La	grade completed) College (1-4or 5 unknown		(Give life. i	dent's Usual Occu kind of work done DO NOT use retire	upation e during most of wored)  18. Mother's Nar			her own	_
Maryland and 2 should be file afth and Mental H; 27 is marked oth	To Be	John Waechter  19a. Informant's Name/Relationship  Helen Harden -	(Type. Print)				Rosa Votand Number or Ru	Vills ural Route Numb	ner, City o	or Town, State, Zi	, ,
Dallimore, Permit. Pages 1 a Pepartment of Her mportant: If Item my Injury or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Specars)  21. Signature of Euneral Service Lice	☐ Removal from State		ace of Dispo emetery, cren ar Law	sition (Name of natory or other plants)  Mem. I	ece) Park 5/1	Date 5/09	20c. Lo	ocation - City or T	own, State , Maryland
Physician /Medical Examiner  Physician and physician and the portial-transit	dical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a conseque	Do not ent	er the mode of dy  Laci		c or respiratory a		wary fluid	Approximate Interval Between Onset and Death
t the death certificate by the attending physic	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗀 Fetal	déath 3 🛭	Ectopic pregnan	icy			23d. Date of deliv Month	very Day Year
w requires that the de been signed by the s should be detached i	þ	Part II. Other significant conditions	contributing to death bu	ut not resul	iting in the ur	nderlying cause gi	iven in Part I.	1 🗆	Yes 2	□ No 3□ Pro	the cause of death?
Physician: The lav physician: The lav prithis certificate has aral director, page 2:	Be Completed	25. Was case referred to medical examiner?	Hospital				26. Place of Dea	1 □ Yes ath (Check only o	psy ormed? 2 (ZINo one)	prior to co death? 1 🗆 Yes	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To	Hospital: 1 Image: 1							ry occurred  and Number or Rur		
To the Hospil within 24 hour To the Funer completely fill	Medical	29a. Certifier (Check only one)  1	Physician: To the best of aminer: On the basis of and manner sta	f examinati	/ledge, death on and/or in	vestigation, in my	time, date and place opinion, death occu se number	e, and due to the irred at the time,	date and	s) and manner as d place, and due to te signed (Month,	to the cause(s)
JH-2		30. Name and address of person wh	o completed cause of de	eath (Item	23a) (Type, I	Print) D(	ele 116	ace	Str	5/12/0°	D 21742
Stat Registra	ar	31. Date filed (Month, Day, Year)  MAY 13	2003 32. Registra	ar's Signatu	ire A	andel		0	-10		

		1 - State of Marylan Registrar		tificate of De			eg. No. 2 () ()	16939	
Physic	ian	Decedent's Name (First, Middle, Last)				Date of Deat Month	Day Year	3. Time of Death	
/Med	ical	HELEN ELIZABETH CONNOLLY  4a. Facility Name (If not institution, give street and number)		4b. City. Town, or Loc	ation of Death	MAY 1	10 2009 0810 A M 4c. County of Death		
Exami	ner	TALBOT HOSPICE HOUSE		EASTON			TALBOT		
Funeral Director		5. Social Security Number  217-80-3335  6. Sex 1 □ M XX F  7. Age (In yrs. 93	last birthday) Yrs.	If Under 1 Year   If I	Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, MARCH 23	Year) 9. Bir Co	thplace (State or Foreign buntry)  MD	
and w		Usual Residence of Decedent  10a. State 10b. County 10c. Cit	ty, Town or Loc	cation				10d. Inside City Limits	
Maryla f sho	p		EASTON					<b>XX</b> Yes 2 □ No	
r 28a	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What Country?			
th with		716 HOWARD ST.		21601			USA		
Ind 21215-0036  be filed within 72 hours after death with the Maryland tital Hygiene.  d other than "natural", or items 23a or 28a-f show event, Inchedical Evan item to routifed a	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 ★ No If Yes, Give Year or Dates:	1	Vas Decedent of Hispa i Yes, specify Cuban, M □Yes <b>XXX</b> No <i>Si</i>	nic Origin? (Spo lexican, Puerto pecify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.	
21215-0036 d within 72 hours aft giene. sr than "natural", or fr the Wedical Exerci-	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during OO NOT use retired)	n ng most of worki		16b. Kind of Business	/Industry	
212 I withi giene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)		MAKER			OWN HOME		
be filec tal Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last)		18.			Maiden Surname)		
Maryland d 2 should be file th and Mental Hy ?7 is marked oth traumatic event	70	SAMUEL THOMAS PLUMMER			DAISY	VIRGINI	A CONRAD		
re, Maryls 1 and 2 should f Health and Mer tem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and				Zip Code)	
		BETTY LUCAS DAUGHTER  20a, Method of Disposition 20b. F		HOWARD ST.		N, MD 21	20c. Location - City or	Town, State	
0 %		★★Burial 2 Cremation 3 Removal from State	cemetery, crem	natory or other place) LL CEMETERY		3-2009	EASTON, MD		
Baltime permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee		Name and Address of ELLOWS, HEI OO S. HARRI	FENBELI SON ST	N & NEWN EASTON	AM FUNERAL , MD 21601	HOME, P.A.	
68/60, tificate be executed Tificate be executed Tificate be executed Tificate be executed Tificate burial-transit Tificate burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cons	juence of):	Car	uce	2/		Onset and Death	
t the death certi by the attending ached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 0 9 ☐ Unknown	al death 3 death 5 death	Ectopic pregnancy			23d. Date of de Month	Day Year	
rdS, F quires tha n signed	호	Part II. Other significent conditions contributing to death but not res	ulting in the ur	nderlying cause given in	Part I.	1 TY	bacco use contribute t es 2 No 3 F	orthe cause of death?  Probably 4 Unknown	
VITAI HECOTAS, iclan: The law requires t certificate has been signe ector, page 2 should be c	Completed					24a. Was a autops perform	med? prior to death?	utopsy findings available completion of cause of s 2  No	
SION OT tending Physicath.  tor: After this the funeral directions.	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No	28b. Time of Injury	ot 3 DOA Other:  28c. Injury at Work?  M 1 Yes	4 Nursing Ho	of Death Check only one)  sing Home 5 Residence 6 Other (Specify) OS Picce  28d. Describe how injury occurred			
DIVISION At results after defined in by	Certifi	4 Homicide determined building, etc. (Specific	ry)			City or Tow			
To the Hospital of within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my known one)  Certifying Physician: To the best of my known one of the best of the best of my known one of the best	owledge, death ation and/or in	n occurred at the time, vestigation, in my opinio	date and place on, death occur	, and due to the or rred at the time, o	cause(s) and manner a date and place, and du	as stated. e to the cause(s)	
To t with	Ž	29b. Signature and title of certifier	MI	29c. License nu	37(_	> 4	29d. Date signed (Mon	th, Day, Year)	
IORK		30. Name and address of person who completed cause of death (Iter	m 23a) (Type, I	Print)	Ave	Deit	OU 48	221629	
Si Regis	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signal 32. Registrar's Signal 33. Registr	ature	facel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Year</sup> 2009 Day **Physician** 12 6:15 p M Margot A. Conant May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil Elkton Health & Rehabilitation Center Elkton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth **Funeral** Days Hours 219-22-1304 81 November 29, 1927 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Elkton Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21921 2907 Pebble Beach Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. d other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Interportant: I fem 27 is marked other than "natural", or iter Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examines 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Household Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Dorothy Cox ပ J. Warren Albinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 525 Albany Ave., Takoma Park, MD 20912 Milford H. Sprecher/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) West Chester, PA May 15, 2009 R A Ferris & Co., Inc. 21. Sig tu paperal so rvice Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Severe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Breast CA = mets to Spine burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Be 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be execute P.O. Box 68760, Division of Vital Records,

the Maryland

death with

Saltimore, Maryland 21215-0036

after death.

Director: Af
d in by the fur i 24 hours af e Funeral D letely filled in within 2

Medical Certification: To N/A 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 × Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

(Check only one)

SHAHNAWAZ KHAN MD

and manner stated

D0062190

5-13-2009

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

WEST HIGH STREET, SUITE 105, ELKTOM MOZIAZI SHAHNAWAZ KHANMO 111 31. Date filed (Month, Day, Year)

State Registrar



12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 **Physician** MAY MARGARET ANN COOKSEY 2009 7:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6160 Ripley Way La Plata Charles 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 6.8<sup>Yrs.</sup> 220-38-4999 July 14,1940 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director La Plata MD Charles 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ant of Health and Mental Hygiene.
ant of Health and Mental Hygiene.
It fiem 27 Is marked other than "natural", or items 23a or :
ury or other traumatic event, It's Machol Exprinter mat bur 6160 Ripley Way S. A. 20646 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I. Cecil Wise ပ Mary Darnell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra Robert V. Cooksey/Spouse 6160 Ripley Way La Plata, Maryland 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 21,2009 | Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem.Grdns. 22. Name and Address of Facility Raymond Funl. Service, P.A. attire of Funeral Service 1 M00641 5635 Washington Ave., La Plata, MD 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Sclerosis Inknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the aftending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 24 hours after death.

• Funeral Director: After this certificate has been signed by the setely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ş 1 ☐ Yes 2 ②No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 ☐ Yes 2- No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1√ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00550883 2004 agour, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11655 WINRSup pl capterfor Tagouri M.D. 1165

Day, Year)

32. Registrar's Signature

MAY 27 2009

Acres A Yahia M.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

**ORIGINAL** 

210

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** рм Marie Carol Daigle 5, 4:30 May 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, **Funeral** Vear) Min. Months Days Hours 1 □ M 2 🖳 F Yrs Director July 16, 1946 Pennsylvania 195-38-3593 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Exercitor roust be notified at 1 ☐ Yes 2 € No Director Maryland Montgomery Burtonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō death with or items 23a 20866 USA 3412 Greencastle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Welfall Eventance. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 2 3 ☐ Widowed 4 ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Financial Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Gerald Taylor Marie Largay ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13620 White Stone Court, Clifton, VA 20124 Amy Daigle Miller/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11, 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, . W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or con-shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pne cause on each line. Immediate Cause (Final disease or condition resulting in death) Septic Shock **Physician** /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Encephalopathy and burial-trar Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐Yes 2 🙀 No 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform certificate 2**X** No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes XXNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death

Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft ie Funeral Di sletely filled ir 29a. Certifier 📧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 manica D66893 May 5, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Majid Rahmanian, MD 31. Date filed (Month, Day, -Year) State Registrar

Please Type or Print in Black Indelible 18k2 Ensure of Item 23a per phys. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5/8/09 7:04 PM Edward O. Darwin 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 9/15/1932 5. Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1**X** M 2□ F 76<sup>Yrs</sup> 135-26-9151 NJ Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 7200 3rd Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Business Executive</u> Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Darwin Elizabeth Stalzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth Lancos - daughter 4616 Isaac Dr. Ellicott City, MD 21043 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Hanover, MD. Ardent Crematory 5/11/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Furgeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 400845 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic SHOCK Due o (or as a consequence of): Respiratory Failure Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 C Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{\text{Q}}\) Other (Specify) \( \text{\text{DV \( \text{V} \) \( \text{Mo\text{V\( \text{L} \)}}\) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No

burial-transit signed by the attending physician and I be detached for use as the burial-tran 68760 pe P.O. Box Records. of Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director; After this certifica Division

**Physician** 

**Examiner** 

10a. State

MD

Director

Funeral

2

Completed

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Examiner

Physician/Medical

Completed

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Certification: To

Medical

2 Accident

3 ☐ Suicide

29a, Certifier

29b. Signa

30. Nam

4 ☐ Homicide

**Funeral** 

Director

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ir than "natural", or items 23a or 28a-f sho

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: if Item 27 is marked other this any lijury or other traumatic event, I'm once.

**Physician** 

/Medical

Examiner

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

3021 Registrar

State

31. Date filed (Month

6 ☐ Could not be

determined

ss of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RST WESTMINSTER, MD2115

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Alfred Eugene Edwards, Sr. 2009 May 16, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funera! 1⊠M 2□ F Sept. 231-20-1470 80 8, 1928 Georgia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Experience rust by soliting at 1 ☐ Yes 2 X No Director Anne Arundel MD Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number death with 116 North Meadow Drive 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Everett Edwards Violet Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trainonce. Wife- Elba H. Edwards 116 North Meadow Dr. Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mine Road Bapt. Ch. 5/21/2009 Spotsylvania Co., VA 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility 21. Signature of Mineral Covenant Funeral Service Fredericksburg, VA 22408 /rew MD 1471 00 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Tusings caldiacon spiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PSIS disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner endamembranous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra physician s the burial Box 68760, Stage Renal Disease Physician/Medical attending p IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Live birth 2 Fetal death Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) JYes 2 □ No ate has been signed by the page 2 should be detached Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed brillation, Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? aronary Artery
as case referred to medical
examiner? 1 ☐Yes 2 ☐ No Disease 1 □Yes 2 Be ( 26. Place of Death (Check only one) funeral director. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No → Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Alatural n 24 hours after death.

Ie Funeral Director: Af
oletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hou

To the Fune

completely fi (Check only and manner stated. 29d Date signed (Month, Dav. Year) 29b. Signature and title of certifier dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and HAMLETTE, M.D TEVEN 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Cei	rtificate of Death		Reg. No.	009	16945	
k	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Nellie Mae Fletcher			2. Date of De Month		:009 <sup>ear</sup>	3. Time of Death 10:24P. M	
j	Examin		4a. Facility Name (If not institution, give street and Frederick Villa Nursin		4b. City, Town, or Location of Death Baltimore			4c. County of Death Baltimore		
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ∏ F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Bir (Month Da May 3,	1.924	9. Birthp Coun Mary	lace (State or Foreign try) Land	
	Maryland a-f show ified at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince George'	s Beltsvill				1	0d. Inside City Limits 1 ☐ Yes 2X No	
	th with the 23a or 28a ist be not	Funeral Director	10e. Street and Number 4305 Vergie Avenue		10f. Zip Code 20705		0	Citizen of What Country? United States		
030	be filed within 72 hours after death with the Maryland to Hylgiene.  did Hylgiene.  did other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes,	s 2 <b>X</b> TNo	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: W		
9500-61213	within 72 ho iene. • than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12)  Colleg	16a. Dece (Give life. Bookk	dent's Usual Occupation kind of work done during most of work DO NOT use retired)  eeper	king		of Business/Ind	rinting	
yland 2		To Be Co	17. Father's Name (First, Middle, Last)  Jasper W. Riley	-	18. Mother's Nam Nina Oli	*		rname)		
Mar	and 2 should beath and Meni n 27 Is marked ner traumatic e		19a. Informant's Name/Relationship (Type. Print) Carlos Dwight Fletcher		ng Address <i>(Street and Number or Ru</i> B <b>ox 97</b> 6 Stevensvi				Code)	
Baitimore,	Pages 1 ament of He ant: If Item ury or other								Virginia	
Rail	permit. Page Department Important: If any injury o		21. Signature of the ray Source Licens Bond of Views of Each Wordt Funeral Home, PA 4400 Powder Mill Road Beltsville, Mar 23a. Part 1. Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	at caused the death. Do not en in each line.  10 10 10 10 10 10 10 10 10 10 10 10 10 1	ter the mode of dying, such as cardiac	OT respiratory	arrest,		Approximate Interval Between Onset and Death	
	Examiner ansit	Examiner	Sequentially list conditions, lidary, Lading to instruction cause. Enter Underlying Cause (Disease or injury that initiated eyents	b.  Due to (or as a consequence of): ause (Disease or injury)						
68/60,	certificate be executed iding physician and ise as the burial-transit	Medical Exa		to (or as a consequence of):						
O. Box 6	death certif e attending d for use as	Physician/Mec	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d	I. Date of delive	ery Day Year	
rds, P.	The law requires that the dite has been signed by the age 2 should be detached	by	Part II. Other significant conditions contributing t	o death but not resulting in the u	underlying cause given in Part I.		tobacco use  Yes 2□		he cause of death?	
Vital Record	The larate has page 2	Completed					s an 2 opsy formed?	24b. Were auto prior to co death? 1 ∐Yes	opsy findings available impletion of cause of	
sion or vita	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	25. Was case referred to medical examiner?  O								
Division	ital or Atters after des ral Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Pl	ace of injury - At home, farm, st uilding, etc. <i>(Specify)</i>	reet, factory, office	28f. Location City or To	(Street and Nown, State)	Number or Run	al Route Number,	
29a. Certifier 29a. C							lace, and due t	o the cause(s)		
	3		Robert Sewar MD D50303 511)09  20 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Rodolto E. Fernandez 516 N. Rolling Rd Ste Zos Cetonsville, N.:  31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAY 12 2009 Linear B. Jane						19	
Ş	Sta	ite	Rodolfo E. Fernand 31. Date filed (Month, Day, Year) 3	ez 516 V. 2. Registrar's Signature	. Kolling Rd S	te 20 9	s Cet	onsve	lle, MJ	
	Regist		MAY 12 2009	Geneva B. 19	back					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	iryland		tificate of		d Mental Hy	gien Reg. No	2009	16946
Ī	Physicia /Medic		1. Decedent's Name (First, Middle, Las Richard MacDonous						2. Date of De Month May	5, Da	<sup>ay</sup> 200 <del>9</del> °	3. Time of Death 8:02A . M
	Examin		4a. Facility Name (If not institution, give 3114 Gracefield 1		2		4b. City, Town, or Silver		eath	40	. County of Death Montgome	ery
	Funeral Director		5. Social Security Number 577-46-3064 6. S	ex 7. Age	(In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	lin. B. Date of Bit (Month, Date of Bit Dec. 4,	in 1927	9. 8irthp Copr Kenti	nlace (State or Foreign http:/ UCky
	Maryland I-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Silver Spring							10d. Inside City Limits 1 ☐ Yes 2X No		
	with the	i Direc	10e. Street and Number 3114 Gracefield Re	oad, WC412			10f. Zip Code 20904			10g. Citizen of What Country? United States		
036	y within 72 hours after deeth with the Maryland jiene. r then "naturel", or Items 23s or 28s-f show Ite Medical Exartinat renet the notified at	ed by Funeral Director	11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 TYPs 2 N If Yes, Give Year or Dates:	0	1	Was Decedent of H f Yes, specify Cuba	ispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or No uerto Rican, etc.)	)-	14. Race - Americ Black, White, Specify: Wh	
9500-9121	within 72 ho ene. then "natur ne Mudical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed)  College (1-4or 5	+)	16a. Deced (Give life. I	lent's Usual Occup kind of work done DO NOT use retired	ation during most of d)	working		Kind of Business/Ind lucation	dustry
andz	oe filer al Hyg d othe	Be	17. Father's Name (First, Middle, Last) Louis Frank						Name (First, Middle	, Maide		
Maryland 2	d 2 should the end Ment 7 is marked traumatic	To	Louis Frank  Jean MacDonough  19a. Informant's Name/Relationship (Type, Print)  Justin X. Frank -son  19b. Mailing Address (Street and Number or Rural Route Num  11302 Odell Farms Court Belts						er, City			
Baltimore, I	Pages 1 and nent of Health int: If item 27 iry or other ti		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of the content o	Removal from State	20h Bl	no of Dispo	cition (Name of		Date	200 1	anation City of To	
Balti	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Licer	9500	/	Ďí /u	DHalland Vidre	Borgwan	rdt Funer	əl H	Home, PA	yland 20705
•	Physician /Medical Examiner street partial street partial fransit street partial fransit parti	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responded, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):							irrest,		Approximate Interval Between Onset and Death
.O. Box 68/60	*= D1 d1	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		Ectopic pregnancy	/			23d. Date of delive	ery Day Year		
Vital Records, P.	. The law requires that the death cert cete has been signed by the attending page 2 should be detached for use	Completed by P	Part II. Dther significant conditions of Rheumatoid Arthri						1 24a. Wa. auto	Yes :	death?	posy findings available impletion of cause of
Division of Vital	To the Hospital or Atlanding Physician: T within 24 hours efter death.  To the Funeral Director: After this certificet completely filled in by the funeral director, pr	25. Was case referred to medical examiner? 1   Yes   2   No							Death (Check only)  ng Home 5 ☒ Res  28d. Describe	one) idence	6 ☐Other (Special	
DIVIS	Ital or Atta irs efter de ral Directo	Certification:	3 Suicide 6 Could not b	building, etc	: (Specify)	)	eet, factory, office		City or To	wn, Sta		
	the Hosp in 24 houths the Fune pletely fil	edicai	(Check only 2 Medical Examone)	nysician: To the best on the basis of and manner sta	examinati	vledge, deat on and/or in	vestigation, in my o	ppinion, death o	lace, and due to the occurred at the time	, date a	nd place, and due t	o the cause(s)
)	D T	Σ	29b. Signature and title of certified	In The	ech	les.	29c. Licens	023649			7 6, 2009	∪ay, Year)
			30. Name and address of person who John Stuckey, M. I	0. 3110 Gr	əcefi	eld R	Print) Dad Silve	er Sprin	ng, Məryl	ənd	20904	
	Sta Registr		31. Date filed (Month) Day, Year)	09 Pegistra	ar's Signal	ha	N. J					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** :40 A. 2009 Fletcher Agnes Louise /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 □ M 2XX 8/17/1934 216-64-2565 Washington DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10h County 10a State 28a-f show injury or other traumatic event, the Medical Examinst must be notified at 1 ☐ Yes 2X☐ No MD Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 n and Mental Hygiene. is marked other than "natural", or items 23a 7900 Vintage Circle Apt C USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) P.G. County Elementary/Se2ondary (0-12) College (1-4or 5+) School Bus Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be William Irene Perry Fletcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Angela M. Hall 7900 Vintage Circle Apt C. Glen Burnie, MD 21061 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1XI Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 5/13/09 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility 21. Signature of Funeral Service Licenses 851 Annapolis Road Gambrills,MD 21054 Hardesty Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a o nsequence of): Examiner The law requires that the death certificate be executed burial-transit pronon Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 BNo 4 ☐ Pregnant at time of death 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>ک</u> 3 Probably 4 Unknown 2**X** No 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State

Registrar

(Check only one)

30. Name and ad

29b. Signature and title of certifier

29c. License number

Glen

Byrnie -mo

29d. Date signed (Month, Day, Year)

2009.

and manner stated.

ess of person who completed cause of death (Item 23a) (Type, Print)

AND.

	Division of Vital Records, P.O. Box 68760,
^	To the Hospital or Attending Physician: The law requires that the death certificate be executed
	within 24 hours after death.
1	To the Funeral Director: After this certificate has been signed by the attending physician and

		Please Type or Print in Black Inde				
	-	State of Maryland / Depart State Registrar  State of Maryland / Depart	ment of Health and M ficate of Death		ene <sub>g. No.</sub> 2009	16948
		Decedent's Name (First, Middle, Last)		Date of Death     Month		3. Time of Death
Physicia: /Medica		Carol K. Forthofer		04	30 200	
` Examine	r	,	b. City, Town, or Location of Death  Annapolis		4c. County of Deat Anne Ar	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, 10/27/	year) 9. Birt	thplace (State or Foreign ountry)
Director	-	311 14 0814 1 M 2 LAF 90 Yrs. Wusual Residence of Decedent		10/27/	1918   M	issouri
ryland how	_	10a. State 10b. County 10c. City, Town or Locati	ion			10d. Inside City Limits
he Ma	Director	MD Anne Arundel Annapoli	S 10f. Zip Code	10	g. Citizen of What Co	1 □Yes 2 No
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, Ire Madeal Examiner must be rutilled at		10e. Street and Number 7308 River Crescent Drive	21401		USA	
ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was 15 of	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
s after	by FL	1 Never Married 2 Married 1 Tyes 2VINO	Yes XXIII Specify:		Consider	hite
2 hour	ted	15. Decedent's Education 16a. Deceden	it's Usual Occupation  d of work done during most of workir	1	6b. Kind of Business	
/ithin 7	mple	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)		Own Home	
filed v I Hygie other t ent, II	Be Completed	17. Father's Name (First, Middle, Last)	18. Mother's Name			
uld be Mental arked a	90	William H. Kendall	Orrel F	yer		
to sho th and in its me reaume			Address (Street and Number or Rura Canvasback Ct			
t Health f Health tem 27 other tu	ŀ	20a. Method of Disposition 20b. Place of Disposition			0c. Location - City or	
Pages ment of I		4 Donation 5 Other (Specify)  Metropol	itan Crtmy 5/		Alexandr	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Examination and once.		21. Signature of Funeral Service Licensee Ad	lame and Address of Facility vent Funeral δ	. Crema	nnapolis tion Svc	MD 21401
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac of	r respiratory arre	st,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):				
Examiner		Colon Conco				
ed sit	Iner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury				
s be executed sician and burial-transit	Examiner	resulting in death) Last C				
be licia		d				
eath certific attending pl for use as t	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	Nivery
death of atten	Physician/Medical	230. Was decedent pregnant in the past 12 months?  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  1  \[ \subsection \]  2  \[ \subsection \]  1  \[ \subsection \]  2  \[ \subsection \]  1  \[ \subsecti	ctopic pregnancy Other (specify)		Month	Day Year
hat the deed by the detached		9 ☐ Unknown[, \ Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
quires that n signed I	g D			1 □ Ye	s 2□No 3□F	Probably 4 Unknown
law requir as been s 2 should	Completed			24a. Was an	24b. Were a	utopsy findings available completion of cause of
The law icate has b				perform		
sician: The certificate irector, pag	Be (	25. Was case referred to medical examiner?  Hospital:	26. Place of Death			
iding Phys	n:	1 Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient  27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)	3 DOA 4 Nursing Ho		nce 6 □ Other (Spewinjury occurred	ecity)
tendin eath. or: Af the fur	catio	2 Accident investigation	M 1 □Yes 2 □No			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	28f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
Hospi 24 hou Funer etely fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investance and manner stated.	occurred at the time, date and place, stigation, in my opinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner a ate and place, and du	as stated. le to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Mon	ith, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri			11101	, ^ /:
964		31, Date filed (Month, Day, Year) 32. Aegistrar's Signature	Medical Bo	Kury	Annapor	19612 MM S1401
Stat Registra	1	31. Date filed (Moth, Day, Year) 2009 32. legistrar's Signature	Ne I	J	,	
HMH 17 Rev 1/20	01		<del></del>			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Of Ma	aryland / Depa <i>Cer</i>	rtment of F tificate of L			ene g. No 2009	16949		
	Physicia		Decedent's Name (First, Middle, Last)  RAYMONI	) HAROLD FO	ORD, JR.		2. Date of Death Month May	7, Day Year 2009	3. Time of Death 6:29 A M		
v.	/Medic Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea	th		
			Suburban Hospital		Bethesd		- B - / B'-d	Montgome			
	Funeral Director		216-38-2452 1 <sup>1</sup> X <sup>M 2</sup>   F	e (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 22,	Year) Co	thplace (State or Foreign ountry) ryland		
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits		
	Mary a-f sh ffied	tor	Maryland Frederick	Frederick					1 XYes 2 □ No		
	or 28	Director	10e. Street and Number		10f. Zip Code		10	og. Citizen of What Co	ountry?		
	s 23a	ral	224 East Fifth Street	110	21701	ionania Origina (Co	ooifu Voo or No	U.S.A.	orican Indian		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ite Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent 1 Armed Forces?  1 □ Yes 2 ★ In Yes 2 ★ In Yes Give Year or Dates:	lo l	was Decedent of H fYes, specify Cuba I⊡Yes 2 ANO	ispanic Origin? (Sp un, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit			
Baltimore, Maryland 21215-0036	n 72 hou "natura	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o OO NOT use retired	ation during most of work f)	ing 1	16b. Kind of Business	/Industry		
212	d within giene.	m o	Elementary/Secondary (0-12) College (1-4or 5	+) Wo	ork Leade			Govern	ment		
and	ould be filed Mental Hygi arked other atic event, i	Be	17. Father's Name (First, Middle, Last) Raymond Harold Ford, Sr.			<sup>18.</sup> Mother's Nam Kathleen		faiden Surname)			
aryl	2 should be and Menta Is marked aumatic ev	ဥ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street	and Number or Rui	ral Route Number,	City or Town, State,	Zip Code)		
Σ,	is 1 and 2 is 1 and 2 is Health a item 27 is		Cheryl L. Crookshank / Dau								
ore	Pages 1 in nent of He ant: If iten ant: If iten ary or oth		20a. Method of Disposition  1    Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren		- 1	-	20c. Location - City or			
ţ	it. Pag rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)	Resthaven				rederick,			
Bal	permit. Page Department of Important: If any Injury or once.		21. Signatur Funeral Service Lice See	12	201 NORTH	MARKET S	T., FRED	RAL HOMES ERICK, MD	21701		
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
đ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Co Rowald Arrow Ocuses  Due to (or as a consequence of):								
7	Examiner		Due to (or as	a consequence of):							
	D +	ner	Sequentially list conditions, if any, leading to immediate Due to (or as	a consequence of):							
	ecuter and transi	Examiner	cause. Enter Unidentying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as								
68760,	tificate be executed g physician and as the burial-transit	al E	Due to (or as	a consequence of):							
687	rtificate ng phys as the	edical	d								
Box	eath cerl attendin for use a	Physician/M	in the past 12 months?  4 Pregnant a	2 Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Date of de Month	elivery Day Year		
P.0	at the by th	hys	9 ☐ Unknown				OGo Did tol		to the series of death?		
	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did top		o the cause of death? Probably 4 ☐ Unknown		
eco		Completed	Hypertonson				24a. Was ai	v prior to	utopsy findings available completion of cause of		
Œ Œ	sician; The law certificate has b irector, page 2 sl	Com	1 cholsteal				perform	ned) death?	s 2 No		
Vita	Physician; r this certific ral director, I	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		ot a DOA Oth	or:	th (Check only on				
o	Phy rathis	1:10	27. Manner of Death 28a. Date of Inju		IL 3 LI DOA	4 Li Nursing H		ence 6 Other (Sp ow injury occurred	ecify)		
ön	Attending Phr r death. ector; After thi by the funeral	atior	1 ☑ Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	y, Year) Injury		k? Yes 2 □No					
Division of Vital Records,	l or Atte after des Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, et	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,		
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	ledical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or in	h occurred at the ti	me, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner ate and place, and du	as stated. ue to the cause(s)		
	To the I within 2 To the I complet	Mec	29b. Signature and title of certifier	1	29c. Licens	se number	2	9d. Date signed (Mor	nth, Day, Year)		
	. =1 0		· Cayene B. Casula	N	D 4	0307 A	10	7 MAy 2	2009		
3	10		30. Name and address of person who completed cause of c	leath (Item 23a) (Type, 1564 Opossu		ke, Frede	erick, MI	21702			
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 11 2009	ar's Signature	Kel						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04 **Physician** Mary Grace Fields Gant 2009 11:00p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas Moor Hyattsville Prince Georges 8. Date of Birth (Month, Day, Year 3/17/1930 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F Hours Min. Yrs. 577-36-8983 79 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a -f show any injury or other traumatic event, it. Medical Evanitus in the busoiffed at once. 1 Yes 2 □ No Director MD Prince Georges Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 904 West Haevn Drive 20721 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Specify. þ Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Keeping Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leavy Fields Adline Earls ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rolland D. Gant / Son 904 West Haevn Drive, Bowie, MD 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Memorial Park 5/5/2009 d 4 ☐ Donation 5 ☐ Other (Specify) Olney, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licens Salerie 7400 Georgia Avenue, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final gryenius clevota Candiar Agarage Diseas **Physician** enis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to man equate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 physician Physician/Medical requires that the death certificate the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) Ö 1 ☐ Yes 2 X No 9 Unknown ٦, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Chronic Renal Failum 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown STROKE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy Arrial Fibrillation Consistive heart Fribin certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thir funeral c 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation s after death.

I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D01852 May 4, 2009 nd address of person who completed cause of death (Item 23a) (Type, Print) reenstory Roll Hights : 110 MD 20781 MS 42036 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician 2009 /Medical 4c. County of Death Facility Name (If not institution, give stre Examiner tour Birthplace (State or Foreign **Funeral** Hours Min. Yrs **Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f showing injury or other traumatic event, the Medical Experiment. 10b. County 10c. City, Town or Location 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Bace - American Indian. 1 Never Married 2 Married 1 □Yes 2 No Specify. Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Gibbs ပ္ 19b. Mailing Address (Street and Number or 20b. Place of Disposition (Name of cemetery, crematory or other p 1 ☐ Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensed 105514 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. 23a. Part 1. Enter the lisease, or complications the shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -atal **Physician** carltar /Medical Due to (or as a consequence of): Examiner leans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ≥ ER/Outpatient 3 □ DDA 1 🔲 Inpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) 27, Manper of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 4:35 P M Mary Ellen Gill 12 2009 May 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Months Days 1 □ M 2 💢 F 48<sup>Yrs.</sup> 8, Oct. 1960 Pennsylvania 191-56-8952 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2 X No E1kton Cecil Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21921 USA 807 Blake Rd. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Mattson Donald R. Gill, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Blake Rd., Elkton, MD 21921 Deanna Hall/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 105-17-12009 1 X Burial 2 X Cremation 3 ☐ Removal from State New London Methodist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) New London, PA 22. Name and Address of Facility
R.T. Foard and Jones, Inc.
122 West Main St., Newark, eral Service Licensee 21. Signatu 23a. Partz. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Anoxic Euce ligacity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) (end store) Due to (or as a consequence of) Diales mecella 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one

**Physician** /Medical Examiner death certificate be executed

Box 68760.

P.O. |

Division or Vital Records,

al or Attend after death

To the Hospital of within 24 hours af To the Funeral D

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

traumatic event, the Medical

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once.

filed within 72 hours after death with Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

as the burial-tran and attending physician signed by the a d be detached for Atter this certificate has been si funeral director, page 2 should

Examine Physician/Medical Š Completed Be Certification: filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown

	1 ☐ Yes	2 N	o
27.	Manner of		
	1 Natura	I	5 ☐ Pending investigation
	2 Accide	ent	investigatio

om ceel do

6 ☐ Could not be

28a. Date of Injury (Month, Day Year) . Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Elkton Md

(Check only one) 29b. Signature and title of certifier

2 🗖 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier

29c. License number DO 4823 29d. Date signed (Month, Day, Year) 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 Inpatient

CHIH 223 West man St MI)

and manner stated.

HD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

		1	For State Registrar	State of Maryl		artment of He			ene 009	16953
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	M.	GIOT.	TSCH AL	IC	2. Date of Death Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or L	ocation of Death		4c. County of Deat	
			7862 Cypress Landi				evern If Under 24 Hrs.	0.0.4	Anne Aru	
	Funeral Director		5. Social Security Number 6. Sex 217-72-6577 1□		vrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y 10/12/1	'ear) Co	hplace (State or Foreign buntry) MD
	P		Usual Residence of Decedent	100	. City, Town or Lo	ocation				10d. Inside City Limits
	anyla ehov	٦	10a. State 10b. County							1 ☐ Yes 🏋 🏋 No
	Z8a-f	ect	MD Anne Aru  10e. Street and Number	ndel	Sever	10f, Zip Code		100	g. Citizen of What Co	ountry?
	with i	급	7862 Cypress Landi	no Rd.		101. Esp 0000	21144		USA	,
	na 23	era		12. Was Decedent Ever	in U.S. 13.	Was Decedent of His If Yes, specify Cuban,		cify Yes or No-	14. Race - Ame	
36	be filed within 72 hours after death with the Maryland ital Hyglene. id other than *natural', or itema 23a or 28a-f ehow event, it a Madical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 XXo If Yes, Give Year or Dates:			Mexican, Puerto I Specify:	Rican, etc.)	Black, Whit	e, etc. White
21215-0036	2 hou		15. Decedent's Edu		16a. Dece	dent's Usual Occupat	ion		3b. Kind of Business	(Industry
215	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT use retired)	ring most of working	.9		
7	e filed within al Hygiene, I other than vent, It e Ma	Con	10		Super	visor	10. A 1-45 - 4- A 10	(Firms Adiabatic Ada	Cleaning	
Maryland	uld be fill fental Hy rked oth tic even	Be	17. Father's Name (First, Middle, Last)				8. Mother's Name			
3	2 should be and Mental is marked raumatic ev	2	George W. Phillips  19a. Informant's Name/Relationship (Ty.)	no Print)	10h Maili	ng Address (Street ar		Spindler		Zin Code)
Mai	d 2 st th and 7 is r traur	1	Robert R. Gottscha			Cypress La				
	s 1 and 2 should f Health and Mer ltem 27 is marke other traumatic		20a. Method of Disposition		b. Place of Dispo	osition (Name of			Oc. Location - City or	
<u>o</u>			1 ☐ Burial 2X☐Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		matory or other place, Crematory	١ .	2009	Glen Burni	e. MD
Baltimore,	permit, Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License		2:	2. Name and Address	of FacilityHard	lesty Fur	neral Home	, P.A.
	4024G		23a. Part1. Enter the disease or compli	cations that caused the						Approximate
	Pnysician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.	Lung					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):					(
	pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or might)	Due to (or as a cor	nsequence of):					
_	ate be executed obysicien and the burial-transit	Examine		Due to (or as a cor	nsequence of):					
8760,	sicien buria	lcal E		•						
687	ficate p physics the			J					100	
Вох	eath certifica attending ph I for use as th	M/U	23b. was decedent pregnant	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		⊒Ectopic pregnancy			23d. Date of de	
O. B	The law requires that the death certificate be executed take been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown		Other (specify)			Month	Day Y <i>e</i> ar
Δ.	that the ed by detac		Part II. Other significant conditions con	ntributing to death but no	t resulting in the t	underlying cause give	n in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
ecords,	uires thai n signed l	d by						12 Yes	s 2 □ No 3 □ P	robably 4 Unknown
00	w requires been si	Completed						24a. Was an	24b. Were a	utopsy findings available completion of cause of
$\mathbf{c}$	The lav	mo						autopsy perform	ed? death?	s 2 No
Vital		0	25. Was case referred to medical				26. Place of Death	(Check only one		
f V	yslc is ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 🗌 Inpatient	2 ER/Outpatie	ent 3 DOA Othe	. 4 🗌 Nursing Ho	me 5 Resider	nce 6 □Other (Sp	ecify)
n of			27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Work		28d. Describe how	w injury occurred	
Sio	Attending r death.	catl	2 Accident investigation 3 Suicide 6 Could not be				es 2 No	ORA Lagration /Cts	eet and Number or F	hural Pouta Numbor
Division	2 2 2 2	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S		treet, factory, office		City or Town,		lurar noute ruimber,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical C		sician: To the best of my ner: On the basis of exa and manner stated.						
	To th within To th	Me	29b. Signature and title of certifier	DA	'. (L.A)	29c. License	number	(30	Od. Date signed (Mor	nth, Day, Year)
•			30 Name and address of persen who co	ompleted ause of death	(Item 23a) (Type	), Print)	V. Mos	1	Anda Anda	3,2009 Apucism nuya
_			MIGHAENIL	arEND	AWV	445 1	10112	1161	mhal land	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature					
		A*	MAI ~ LUU3	~~ /·	17					

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	State of Maryland / Department of Health and Mental Hygiene	U:

Physician /Medical Examiner	1. Decedent's Name (First, Middle, L Dorothy Emm	ast)					. No.	
Examiner				<u> </u>		2. Date of Death Month May 16	Day Year , 2009	3. Time of Death 1:30 P M
	4a. Facility Name (If not institution, g	ive street and number) etown Road		4b. City, Town, or Parkt	on	th	4c. County of Death Baltim	
Funeral Director	5. Social Security Number 6. 178-28-0620  Usual Residence of Decedent	Sex 1	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1929 Penr	place (State or Foreign nisylvania
r 28e-1 ahow	10a. State 10b. County		, Town or Lo	cation arkton				1 ☐ Yes 2 No
death with the Maryland ms 23a or 28e-f ahow trinial be rediffed at neral Director	10e. Street and Number 19239 Middlet			10f. Zip Code	21120	10g	U.S.A.	ntry?
ē 5 1 1	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 ☑ No	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify: WI	
within hen "	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	College (1-4or 5+)	(Give : life. (	ent's Usual Occupa kind of work done of DO NOT use retired Stered.	furing most of wo )	orking 16	b. Kind of Business/In	•
be fill Mal H aven Be	17. Father's Name (First, Middle, La				18. Mother's Na	me (First, Middle, Ma thy Price		
	19a. Informant's Name/Relationship William L. Hug						City or Town, State, Zipcon, MD 2	
permit. Pages 1 am Department of Heat Important: If Item 2 any injury or other once.	20a. Method of Disposition  13∑ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	□Removal from State Pi	ne Gr	sition (Name of OVE UNI st Ceme	ted May	v 21.	oc. Location - City or T Parkton,	
permit. Departm Importa any inju	21. Signature of Funeral Service Lic		22	. Name and Addres	s of Facility J.	J. Harten	stein Mort	
ficate be executed a physician and street burial-transit street burial-transit edical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sauchtaly list and tons if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	ience of):	andom	etmal	Larcir	noma	Approximate IntervaleBetween Onset and Death
law requires that the death certificate be as been signed by the attending physicia 2 should be detached for use as the but pleted by Physician/Medical		d. 23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy			23d. Date of delive	rery Day Year
tuires that n signed by ald be deta	Part III. Other Style Condition	contributing to death but not result (STOS)	ulting in the ur	nderlying cause give	en in Part I.		cco use contribute to	
The sage						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 2 \square No
Physician: The raths certificate ral director, pag.	examiner*	Hospital:		Othe	00	eath (Check only one)		
en en en en en en en en en en en en en e		28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun	4 □ Nursing y at	28d. Describe how	ce 6 Other (Special injury occurred	ify)
in Diffe	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
Hosp 4 hou Fune tely fill	29a. Certifier Certifying (Check only 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examinat and manner stated.						
To the within 2 To the comple	29b. Signature and title of certifler	I Huslie		29c. Licens	86814	290	d. Date signed (Month	Day, Year)
State	30 Name and address of person with the state o	completed cause of death (Item (15)16 1598 32. Registrar's Signal	1051	Print) DR	. SUIT	E302-	Towson	MD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deat May 9, Year 2009 9:45 РМ Rosemarie Anne Horn 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Rockville Montgomery Casey House If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/28/1957 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 21 F Canada 52 220-70-9013 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20910 2312 Ross Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces
1 ☐ Yes 2X 2X No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 □Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) American Chemical Elementary/Secondary (0-12) College (1-4or 5+) Meetings Planner Society 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Regina Josephina Gadjinski Johann Schmid 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Horn Jr. / Husband 2312 Ross Rd. Silver Spring, MD 20910 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/14/2009 Falls Church, Virginia National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Serticemia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Colon Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐Yes 2 ☐No 1 ☐Yes 25. Was case referred to medical examiner? Hospital: Other 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

al Hygiene. I other than "natural", or items 23a or 200. event, It's Medical Examiner must be nuffled at

permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, It a Medical Examinar must any Injury or other traumatic event, It a Medical Examinar must once.

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

Director

Funeral

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Completed

Be

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the Maryland

Examine Physician/Medical Be

spital or Attending Physician: The law requires that the death certificate be executed rours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit ğ Completed Certification: To Medical

IF FEMALE: 23b. Was decedent pregnant

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

31. Date filed (Mont

5 ☐ Pending investigation

6 ☐ Could not be

determined

26.	Place	of	Death	(Check onl	one)	
	_					

4□ Nursing Home 5□ Residence 6₺ Other (Specify HOSPice 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year)

29c. License number 20063748

29d. Date signed (Month, Day, Year) May 11, 2009

Docelyne towarchou, md 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou MD 6001 Muncaster Mill Rd. Rockville, MD 20855

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

To the Hospital within 24 hours a To the Funeral C

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 05701/2009 Louis Settle Hutchison 1940 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Hospital Center Cheverly Prince Georges 8. Date of Birth (Month, Day, Year) 04/04/1913 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Min 1 € M 2 □ F 95 Virginia 578 03 4648 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 10625 Mattaponi Road USA by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2X No White Specify 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Special Agent FBI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Benny Hutchison unavailable ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Hutchison (son) 10625 Mattaponi Rd/Upper Marlboro MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 5/4/09 Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Services Falls Church VA and Annapolis MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final My Cardia minutes Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conse Examine ng physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 4□Pregnant at time of death 5 Other (specify) signed by the a 1□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe aeute senal insufficiency certificate 1 Yes 2 X No the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Phpatient 2 □ ER/Outpatient 3 □ DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 □ Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

LANDOUER KOAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 11 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHEVERLY

DHMH 17 Rev 1/2001

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

024720

RAVINDER K. PRUSTAG

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month STASSIA RENA HENDERSON 08 2009 12:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4 HENRY WAY **ELKTON** CECIL If Under 1 Year | If Under 24 Hrs 8. Date of Birth Month, Day, JULY 2, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1951 1 □ м 2🛣 F Months Days Hours 239-88-3870 57 Director NORTH CAROLINA Usual Residence of Decedent death with the Maryland 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show 1 XYes 2 □ No Director MARYLAND CECIL ELKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 HENRY WAY 21921 UNITED STATES Funeral 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel any injury or other traumatic event, the Nedical Exercipes once. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 X No Specify Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ADVERTISING TELEVISION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIE ROBERT MARTIN CARTHENIA BERNICE ATKINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL HENDERSON / HUSBAND 4 HENRY WAY, ELKTON, MARYLAND 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State

**Physician** /Medical

**Examiner** 

attending physician and for use as the burial-trar

signed by the betach

certificate ha irector, page 2

4 ☐ Donation 5 ☐ Other (Specify)

Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	21. Signature of Funeral Service Licen	see the Colomon	LISA	nd Address of Facility SCOTT FUNER LEWIS STREET	RAL HOME, P	.A. GRACE.	MD 21078				
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death								
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or as a consequence of):  CDue to (or as a consequence of):  d									
ıysician/Med	IF FEMALE:     23b. Was decedent pregnant in the past 12 months?     23c. If yes, outcome of pregnancy     23d. Date of the past 12 months?       1 □ Yes 2 □ No 9 □ Unknown     9 □ Unknown     23c. If yes, outcome of pregnancy     23d. Date of the past 12 months?       1 □ Yes 2 □ No 9 □ Unknown     4 □ Pregnant at time of death 9 □ Unknown     5 □ Other (specify) □     Month										
mpleted by Pl	Part II. Other significant conditions of	ontributing to death but not resulting in th	e underlying ca	ause given in Part I.	23e. Did tobacc  1  Yes  24a. Was an autopsy performed	2Å No 3☐ I	to the cause of death?  Probably 4 Unknown  autopsy findings available completion of cause of				
					1 ☐ Yes 2 A		s 2 No				
Be	25. Was case referred to medical examiner?	Hospital:									
Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) (Month, Day, Year)	6 ☐ Other (Sp jury occurred	ecify)							
Certific	4 ☐ Homicide determined	building, etc. (Specify)			28f. Location (Street City or Town, St	ate)					
Medical	29a. Certifier 1.★ Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, d niner: On the basis of examination and/o and manner stated.	eath occurred or investigation	at the time, date and place, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner and place, and di	as stated. ue to the cause(s)				
¥	29b. Signature and title of certifier		290	c. License number	29d. I	Date signed (Mor	**				

HARFORD MEMORIAL GRDS 05/15/09

ABERDEEN, MARYLAND

MARYLAND 21921

State Registrar JAMIL KHATRI,

31. Date filed (Month, Day,

SUITE 104, ELKTON

111 W. HIGH STREET

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 6:40 AM Marian Maria Jones 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Prince Georges Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 5, Hours Months Days Min 1 □ M 2 🕅 F 86 1922 219-12-4246 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XYes 2 □No Bowie Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20716 16010 Excalibur Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vita Ferreira Ballato Vicino Joseph Ferreira 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mariann Jenkins/ Daughter 1707 Jasper Lane Crofton, MD 21114 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 5/12/2009 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Inconsee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Weeks Ischemic Cardiomyopathy Due to (or as a consequence of): Acute Myocardial Infarction Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Atherosclerotic Cardiovascular Disease Years Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ath 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Iting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performe 1 □Yes 2 No 25. Was case referred to medical examiner? Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes cify)

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tha any liqury or other traumatic event, the 1 once.

**Physician** 

Examiner

**Funeral** 

Director

d other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at

the Maryland

1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical δ Completed Be Certification: To

27. Manner of Death

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifie

3 ☐ Suicide

29a. Certifier

Division of Vital Records, P.O. Box 68760

tributing to death but not resul
ıt

5 Pending investigation

6 □ Could not be

determined

26. Place of Dea	ith (Ci	neck only one)	
her: 4 🗆 Nursing H	ome	5 Residence	6 ☐ Other (Spec
ıryat	28d.	Describe how inju	ury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

05/08/09

🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examiner stated. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

32261

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Date of Injury (Month, Day, Year)

Feldman, MD 9500 Annapolis Rd, Suik A4, Lanham, MD. 20106 J.

State Registrar

Medical

32. Registrar's Signature 31. Date filed (Month

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

23

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, #201 - State Registrar TCHD, 05/08/2009, TLS Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death d Shith 0.5 Day **Physician** Margaret Matthews Jolley 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heartfields Assisted Living Talbot Easton 8. Date of Birth (Month, Day, Year) 05-20-1908 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours 100 216-18-8087 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County r 28a-f show notified at 1 Yes 2 No Director Cambridge Dochester Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ns 23a or 2 must be n 805 High Street 21613 USA Completed by Funeral iral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Black 'natural", Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Dorchester County (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School System the School Teacher other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked c Daniel Matthews Jolley Josephine ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Corinda Waters/Niece 805 Hight Street, Cambridge, Md. 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 05/15/2009 Department of I Important: If Its any Injury or of once. 1 Ma Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Petersburg Cem. 05 - 16 - 09Hurlock, Maryland 2 Signature of Funera Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 516 S. Main St., Hurlock, md. 21643 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lihe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10+4eas Organie /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed physician are the burial-t Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending pl IF FEMALE: nse . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate ha 1□ Yes 2☑No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Susted hiving 1 Yes 2 No ٥ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No. after death.

Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 - Certifying P ion: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital of within 24 hours aff To the Funeral Discompletely filled in

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State

Registrar

31. Date filed (Month, Day, Year)

Usan E.

29b. Signature and title of certifier

Delen-Bath CHA

29c. License number

29d. Date signed (Month, Day, Year) 05/07/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. E. Delca. BAKIN CANP-8519 Commerce Du +100, EASTON, MD 21654

MAY 0 8 2009

32. Registrar's Signature park

Jones

Edgar

State

Registrar

DHMH 17 Rev 1/2001

MICHAEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUTCHMANS

Division of Vital Records, P.O. Box 68760,

/Medical **Examiner** Hospital or Attending Physiclan: The law requires that the death certificate be executed and attending for use as ned by the a filled in by the funeral after deam. 24 hours a within 2 To the I

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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is 23a or 28a-f show

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Ith and Mental Hygiene.

27 Is marked other than "natural", or traumatic event, It a Medical Example.

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau

**Physician** 

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

disease or condition resulting in death)	15 Chomia	andin	lorther L	over exp	inity W	eeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consec	quence of):	Ascular .	disease	chi	911
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet: 4 □ Pregnant at time of 9 □ Unknown	al death 3 ☐ Ectopio			23d. Date of delivery Month Day	Year
Part II. Other significant conditions con			cause given in Part I.		use contribute to the cause	
				24a. Was an autopsy performed? 1 □ Yes 2-	24b. Were autopsy findir prior to completion death? 1 ☐ Yes 2 ☐ No	ngs availabl of cause of
25. Was case referred to medical examiner? 1 ☐ Yes 2 ■ No	lospital: 1	BER/Outpatient 3□		eath (Check only one)  Home 5 Residence	6 ☐ Other (Specify)	
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	ry occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, factorify)	ory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route f e)	lumber,
29a. Certifier (Check only one)	sician: To the best of my knoner: On the basis of examinand manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the cause(s curred at the time, date an	s) and manner as stated. d place, and due to the caus	se(s)
29b. Signature and title of confifier	=//	2	9c. License number 0 5 4 7 5 6	29d. Da	tte signed (Month, Day, Yea	

DHMH 17 Rev 1/2001

State

Registrar

Name and address of person who completed ca

Year)

31. Date filed (Month, Day

Darke

Tulaste

32. Registrar's Signature

Highway, Suite 203, Haure Debruce, MO 21078

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kum Chuen Kam May 6, 2009 4:55 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Manor Care-Potomac Potamac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) **Funeral** Hours Months Days 1 X M 2 □ F 15, 98 Jan. 1911 China Director 143-66-0800 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprimer must be notified at 1 ☐ Yes 2 X No Director Potomac Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20854 China 10433 Windsor View Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∑XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 至 Asian 3™ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Overseas Chinese Committee Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shiao-Chi Kam Mo-Woon Leung ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10433 Windsor View Drive, Potamac, MD 20854 Josephine Li/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 17, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 2009 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd., W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** stroke /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury) that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transil and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown ģ signed d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒️No 24a. Was an has autopsy perform certificate 2 XNo Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 

Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pon 24 hours after death.

The Funeral Director: After the funeral pletely filled in by the funera Injury at Work? 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) npletely and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ို Ca D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Creorgia Annu #1-17 5il verspring mozogo SUNITHO Blogavilli OD, 31. Date filed (Month, Day, Year) State Registrar

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			State Registrar	41		Cer	tificate of L	<i>Jeath</i>	2. Date of De	Reg. No.	2009	3. Time of Death
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	ms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No	)- 14.	Race - Americ Black, White,	
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Bal	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once.	ļ ļ	21. Signature of Funeral Service Lic	ensee 7 / /	3		2. Name and Addre		_		•	eral Home
	_		23a. Part 1. Enter the disease, $\delta$	mplications that	caused the deal		331 Easte er the mode of dyir				SLOWII,	Approximate
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	To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director; After this certifica completely filled in by the funeral director, to the funeral director.		(Check only 2 Medical E	xaminer: On the	basis of examin	nowledge, dea nation and/or ir	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	e, and due to thurred at the time	e cause(s) a e, date and p	and manner as place, and due	stated. to the cause(s)
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7		l V	30. Name and address of person w	ho completed ca	use of death (Ite	em 23a) (Tvoe	Print)					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #261 - State Registrar FH, tchd, 5/08/09, pha Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY Day **Physician** 2009 4 0303  $\mathbf{P}$  M EVELYN MAY KURTZ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TALBOT TALBOT HOSPICE HOUSE EASTON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 M XX F Months Days Hours Min MD MAY 18, 1924 Director 84 218-14-0428 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show iral", or items 23a or 28a-f shov Examinar met be notified at XXYes 2 No Director TALBOT EASTON MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21601 USA 29721 WYE OAK STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XX Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the McCall Evanciana. Once. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2XXNo Specify. δ 3XXVidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 SALES CLERK RETAIL STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALVERDIA UNKNOWN UNKNOWN SCHACKERT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29721 WYE OAK ST. EASTON, MD 21601 RICHARD S. KURTZ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WHITE MARSH CEMETERY 5-13-2009 TRAPPE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS HARRISON ST. EASTON, MD 21601 HOME, P.A. MOHN MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Physician : Mronic 10 years disease or condition resulting in death) /Medical Due to (or es e consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Wes decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No cate has been signed by the page 2 should be detached 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1arai 1 ☐ Yes 25. Wa ase ferred to medic examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sestimence 6 XXOther (Specify) Hospice Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation nours after death.

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y filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar

31. Date filed (Month, Day, MAY 08

29b. Signature and title of certifier

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32. Registrar's Signature

and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print)

within 2 To the F

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Bettv Jean Kellv May 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Rehabilitation + Nursing Ctr. Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □ XF 7/28/1927 577-32-0706 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c, City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 □Yes 2√□No Funeral Director MD Worcester Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 200 Civic Ave. 21801 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No ò Specify. 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Audit Manager Sears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia Mitchell Willard Dennis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1055 Springhill Way, Gambrills, MD 21054 Donna K. Martin / daughter Baltimoře, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Powellville Cemetery: 5/14/2009 Powellville, MD 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature di Fundial Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Justa 23a. Part I. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail ine. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 □Yes 2 □No 24a. Was an autopsy performed 2 40 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩o Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Alatural Injury 1 □Yes 2 □ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours after To the Funeral Dire Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2714 William W. D 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JOHN V. LEWIS, JR /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPITA. umbrid9 Dorchaster Dorchest cnerai 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours Min 1 M M 2 □ F Vrs 80 8/19/1928 213-24-4725 MARYLAND Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 X No Director CAMBRIDGE MARYLAND DORCHESTER 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 954 HUDSON RD. 21613 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify. <u>≽</u> 3 Widowed 4 Divorced WHITE 1050 ... 1052 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STORE OWNER RETAIL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ JOHN V. LEWIS, SR. NAOMI ROSE PHILLIPS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY F. LEWIS / WIFE 954 HUDSON RD., CAMBRIDGE, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. JOHN' S CHAPEL CEMETERY ! 5/20/2009 CAMBRIDGE, MD 21. Signature of Funeral S 22. Name end Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardiomy disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 2 200 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 1 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide

Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be execute thours after death.
Funeral Director: After this certificate has been signed by the attending physician and P.0.

**Funeral** 

Director

28a-f show

ò items 23a

ò

'natural",

permit. Pages 1 and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturary injury or other traumatic event."

Physician

/Medical

burial-tran

attending physician for use as the burial

detached signed by t i be detach

funeral director, page 2 s

filled in by the

completely

Medical

24 hours a

within 2.

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

Examiner

traumatic event, the Medical Examiner must be notified at

72 hours after

altimore, Maryland 21215-0036

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1		30. Name ar	nd add	ess of p	erson v	vho com	pleted	cause of dea	th (Item 23	Ba) (Type,	Print)	anh	enter	- Acu	Cam	bridge,	mo	21613
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Stat	e	31. Date file	d (Mor	ith, Day	Year)	1	3	2. Registrar	Signature	e Ke	1							
stra	ar	[7] F	11 %	51 4	CUU.	M	The same	4 1	· M.	and a								

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

m.1).

end manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** Leslie, Sr. Thomas Clinton 08:15AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 8, 9. Birthplace (State or Foreign **Funeral** Min. 1**X**M 2□ F Months Days Hours Country) Maryland 577-46-1652 Ĩ9̃35 73 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Modical Evantics must be notified at 10a State 10b. County Director 1 ☐ Yes 2 No MD Washington Boonsboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9347 Childacrest Drive U.S.A. 21713 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 📉 No Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2K Married Maryland 21215-0036 1 □Yes 2 No Specify: <u></u> Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Grocery Food Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leon Sperry Leslie Bernice Downs ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 21713 Anna M. Leslie/Wife 9347 Childacrest Drive, Boonsboro, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 5/18/2009 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COAGULOPATHY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner REPAIR OF ANEURYSM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of n the death certificate be executed burial-trar Due to (or as a consequence of): O. Box 68760, ed by the attending physician Physician/Medical the SB IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>음</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown CORONARY ARTERY DISEASE The law requir Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CHRONIC OBSTRUCTIVE PULMONARY DISEASE has After this certificate has funeral director, page 2 autopsy performe 1 ☐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MAY 14, 2009. D41749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REICHMAN, 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) AAY 2 7 2009 2. Registrar's Signaure State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 6:32 AM MARGARET 2009 LER CH 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth Month, Day, Ye Nov 15, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 F 212-20-1953 84 Pennsylvania Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b County or than "natural", or items 23a or 28a-f show the Medical Eventine rough by notified at 1 ☐ Yes 2 X No Director Port Republic Maryland Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20676 3245 Southern Pine Lane Funeral hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be pe Josephine Marie Dolphin Frank Robert Moran ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3245 Southern Pine Lane, Port Republic, MD 20676 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra John K. Lerch/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 1 2009 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Dother (Specify) 21. Signal re of Fu eral Service Licersee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Kehard 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CLOSTRIDIUM DIFFICILE COLITIS 3 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ē Due to (or as a consequence of) Examin requires that the death certificate be executed and physician a Due to (or as a consequence of): Box 68760, Physician/Medical the as attending I IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 2 No ed by the a Ö 9 Unknown 9 Unknown signed by t σ. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown FAILURE TO THRIVE page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' After this certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of D66753 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21401 CAPSTACK NO, 2001 MEDICAL BARKWAY ANNAPOLIS TIMOTHY M. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland		rtment of l			giene 2 Reg. No.	009	16969
	Physicia /Medio		Deborah M. Lawre					2. Date of Dea Month	5, Day	20Ŏ9 <sup>r</sup>	3. Time of Death 5:00P • M
1	Examin		4a. Facility Name (If not institution, give 11419 Rosedale La	street and number) ne		4b. City, Town, o	in Location of Death $ille$			unty of Death nce Ge	orge's
Ī	Funeral Director		210-00-3307	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pa) Nov • 15,	1955	9. Birthp Cour Mary	place (State or Foreign Try) Land
	Maryland a-f show ified at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland		Town or Lo an He					1	0d. Inside City Limits 1 ☐ Yes 2 No
	with the	I Direc	10e. Street and Number 6015 Bicknell Roa	d		10f. Zip Code 20640			-	of What Cour ed Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Its Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: Wh	
Baltimore, Maryland 21215-0036	within 72 hou ene. than "natura"	Be Completed by	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece (Give life. I		pation during most of work ed)	ing	16b. Kind	of Business/In	dustry
yland 2	vuld be filed v Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Carlos Midkiff				18. Mother's Nam	Patton			
Mar	nd 2 sho alth and 27 is ma er trauma		19a. Informant's Name/Relationship (T) Brian D. Fisher -b				t and Number or Ru Road Ind				
more,	Pages 1 a nent of He ant: If item ary or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Burial 2 ☐ Cremation 5 ☐ Other (Specify)	removal from State	ace of Dispo metery, crer : Linc	sition (Name of natory or other pla oln Ceme	tery 5/8/	Date 2009 E		tion - City or To	own, State Jaryland
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licens	ee wet	D6	Name and Addr nald V. 00 Powde	Borgwardt r Mill Ro	Funeral ad Belts	l Home sville	e, PA e, Mary	land 20705
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or compshock, or heart failure. List only old Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	ications that caused the death ne cause on each line.  a. Lung Cancer  Due to (or as a consequence).  Due to (or as a consequence)	ence of):	er the mode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
260,092	death certificate be executed e attending physician and d for use as the buriat-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause there underlying that initiated events resulting in death) Last	Due to (or as a consequent	ence of):					14	
P.O. Box 68	death certific e attending p d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[	☐ Ectopic pregnar ☐ Other <i>(specify)</i>	псу		236	d. Date of deliv	very Day Year
rds, P.	w requires that the de been signed by the should be detached	2	Part II. Other significant conditions co	ntributing to death but not resu	ting in the u	nderlying cause g	iven in Part I.				the cause of death? bably 4 ☐ Unknown
al Records,	2 8 2	Completed							psy prmed? 2 No	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
ĭ Vit	hystciar his certif I directo	To Be	To res ZEINO	Hospital: 1 ☐ Inpatient 2 ☐ I		nt 3 🗆 DOA	26. Place of Dea ther: 4 ☐ Nursing H	ome 5 ☐ Resi	dence 6	Xother Par	ent's home
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At ho- building, etc. (Specify	28b. Time o Injury me, farm, st	M 1	∃Yes 2⊟No	28f. Location (City or To	Street and i		ral Route Number,
_	To the Hospital or At within 24 hours after o  To the Funeral Direct completely filled in by	Medical Ce	29a, Certifier Certifying Phyone) Medical Example 2	ysician: To the best of my know finer: On the basis of examinat and manner stated.	vledge, dea ion and/or in	th occurred at the ovestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	Withir comp	Me	29b. Signature applittle Certifis				nse number 0055065			signed (Month	
		1 1	On Name and advance of parent who a	ampleted sauce of death (Item	22a) (Tuno	Print)					

State Registrar 31. Date filed (Month, Day, Year)

MAY 07 2009

Martin Joseph Edelman, M.D.

22 S. Greene Street Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 **Physician** 2009 3:15 A M Esther Mae LaPole /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☐ XF 80 MD 219-20-7609 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2√☐ No Director MD Berlin Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21811 25 Deep Channel Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify: white Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "na any Injury or other traumatic event, in a Mode. once. Elementary/Secondary (0-12) Unknown College (1-4or 5+) Education Administrator Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Foreman Unknown P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25 Deep Channel Dr., Berlin, MD 21811 Arthur LaPole / husband D = 5/13/Baltimore, I 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 5/12/2009 Cape Henlopen Crem. Frankford, DE 5-Dother (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeal Home 108 William St., Berlin, MD 21811 23a. Part1. Fit / th disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia - Cause (Final disease - r condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 No certificate Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this မ 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number May 12, 2009 D0056307

State Registrar

DOB

-a Pole

DHMH 17 Rev 1/2001

Drive, Berlin, MD 21811

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

J. van Egmond MD, 9733 Healthway

32. Registrar's Signature

J. vain Egmond MD,

MAY 1 3 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death HOMAS F. MACK JR **Physician** 0515 A M 2009 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 802 Forston Street Montgomery Takoma Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You March 8, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** . 1916 Months Days Country) Rhode Island Hours Min. M 2 ☐ F 176-32-2796 93 Director Usual Residence of Decedent 10a State 10h. County 10c City Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Director Maryland Montgomery Takoma Park permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-any Injury or other traumatic event. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 802 Forston Street 20912 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married XX Married Maryland 21215-0036 If Yes, Give Year or Dates: 1941-57 1 TYes 2 TONO Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ma jor U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas F. Mack, Sr. Frances E. Doherty ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Forston Street, Takoma Park, MD 20912 Mauricia Mack/ Wife Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation May 27, 2009 3 Removal from State Arlington National 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia metery 22. Nami and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or conshock, or heart failure. List only ompications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, not see cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostate **Physician** UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2/2 No certificate 1 □Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

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MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHANDAGLE

KENNETH

07

31. Date filed (Month, Day, Year)

D61007

Silver Spring

831 E. University Blvd #25

Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Month **Physician** 8:04 AM Myrtle May Mason 9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbur Wicomico Hospice at 40 Lake If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/19/1929 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Months Hours 80 579-32-7372 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Director 1 ☐ Yes 2 X No Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Mumford St. 21863 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2¥☐No Specify: þ white 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Burt Cummins Marie Barnhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Wells / daughter 8432 Church Lane Rd., Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Eastern Shore Vet. Cem 5/15/2009 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) Service Licence 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Enter in disea shock, or heart failure. disear , or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sh 24a. Was an performed 1 □Yes 2 🗆 No fo the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this nours after death.

neral Director: After this

filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 30 Name and ress of person who completed muse of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 3 2009

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32. Pegistrar's Signature

PO BOX 1733 Salsbury My

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9<sup>Day</sup> Month MAY **Physician** 2009 2.20 A M LEROY MCCANTS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Prince Georges Community Hospital Cheverly Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 23 6 Sex **Funeral** Year Days Hours 1 X M 2 □ F 1959 Manning, 50 Director 249-23-8763 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Eventient in notiting an order. 1 ☐ Yes 2 No Directo MD Prince Georges Ft. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 10720 Featherstone Dr. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐Yes 2 █No Specify. É Specify: 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Citgo Gas Station Mechanic 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elloree Felder Willie McCants, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9303 Pella Pl. Clinton, MD. 20735 Mary McCants-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 5-15-2009 Alexandria, VA. 21. Signature of Fune al Service Licenses 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic encepholopathy /Medical Due to (or as a consequence of): **Examiner** Cardispilminory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Bilatera Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month Dav 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Coagulation ntravascular 2 1 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🗆 No 1 ☐ Yes 2 No 1 Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0043662

State

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

31. Date filed (Month, Day, Year) Registrar

Bon

William

32. Registrar's Signature parke

Horn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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3001 Hospital Dr. Cheverly, Md. 20785

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2 sho		19a. Informant's Name/Relations	nip (Type. Print)			ng Address (Street			•	n, State, Zip	Code)
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1 0 1		39. Name and address of person	who completed cau	se of death (Iter	n 23a) (Type,	Pript) /C -	Ц	A .	/ 1	-) ->	
1094		39. Name and address of person  1. L. H. A.B. J. L.  31. Date filed (Month, Day, Year)	W F NTA	m 44	1 1/	E FNZE	MAHWA	ry 1120	APOUL	MAID.	21401
St Regist	ate	31. Date filed (Month, Day, Year)  MAY 11	2009	Registrar's Signa	ature	a del					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MAC 2009 01411 Barbara A. Nagle /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Washington County Hospital Md. Washington Hagerstown, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F 175-30-2121 70 Director Sept. 18, 1938 Cresson, Pa. Usual Residence of Decedent death with the Maryland 10a, State 10h County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examirer must be notified at 1 X Yes 2 ☐ No Directo Franklin Pa. Greencastle 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 So. Allison St. 17225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examir or 1 ☐ Never Married 2 ▼ Married Baitimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 English Teacher 4 +Middle School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Briel ပ Cecelia Costello 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 238 So. Allison St., Greencastle, Pa. 17225 <u>Joseph Nagle-Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)

Keystone Cremation May 20,
Center LLC 2009 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Tyrone, Pa. 16686 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, hagerstown, 21. Signature of Funeral Service Licenses R. hall Brad Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancel **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner telin do Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ÑNo Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy perform 1 ☐Yes 2 X No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. \_\_ 3. Time of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 1141 AM **Physician** PRUE 5 09 EBORAH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Takoma Park Montgomery HOSPITAL WASHINGTON ADVENTIST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes Jan. 10, 9. Birthplace (State or Foreign 5. Social Security Number Year) Min Days Hours 1 □ M 2 □ XF 1952 Maryland 220-54-4362 57 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 📆 No Director Brookeville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3304 Gold Mine Road 20833 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc 1 ∐Yes 2 1 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☑No Specify: White Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellsworth H. Henson Hazel A. Tosten ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Ronald J. Prue/Husband 3304 Gold Mine Road, Brookeville, MD 20833 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State May 9 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Tehard L Halo 500 University Blvd., W,. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SOMPLICATIONS FROM GASTRIC TUBE PLACEMENT Immediate Cause (Final 15 MINUTES disease or condition resulting in death) Due to (or as a consequence of): MOXIC ENCEPALOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ARDIAR TAMPONADS Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery gnant 3 Ector iths? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify nt conditions contributing to death but not resulting in the order of cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 N Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traur once.

**Funeral** 

Director

28a-f show

death with

d other than "natural", or items 23a or 28a-f shov event, in the dical Examiner must be recilied at

d 2 should be filed within 72 hours after th and Mental Hygiene.
7. Is marked other than "natural", or ite traumatic event, the firedical Examination

altimore, Maryland 21215-0036

Examine

Medical Certification: To Be Completed by Physician/Medical Examir
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
within 24 hours after death. <b>To the Funeral Director</b> : After this certificate has been signed by the attending physician and
To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1	EMAL Was in the 1   Y	dece pas es	dent pre t 12 mor 2 No
Part	II. Oth	er si	gnificar
25.	examir	ner?	eferred t 2 ∏ No
27.	Manne		

4 Homicide

29b. Signature and title

29a. Certifier (Check only one)

25. Was case referre examiner?		Но	spital: 1 🔀 Inpatier
7. Manner of Death 1 Natural 2 Accident 3 Suicide	5 Pending investigation	1	28a. Date of Injury (Month, Day, may 5 2 28e. Place of Injur

ca to mealour		
No	Hospital: 1 Inpatient 2	
5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day, Year)	7

<b>≾</b> Inpatient 2□	ER/Outpatient	3 🗆 🛭	AOC	0
te of Injury onth, Day, Year)	28b. Time of Injury		28c.	
Pitas D.	1146	M		1

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Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes	2 1
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arm street	facto	irv of	fice	

Other: 4	☐ Nursing H	lome	5 Reside	nce
njury at Nork?		28d.	Describe ho	w i

Н	ome	5 Residence	6 ☐ Other	(Specify)	
	28d.	Describe how inju	ury occurred	1	1
	D	uring PE	FG (	1/45	enen
_	28f.	Location (Street a City or Town, Sta	and Number	or Rural R	oute Number € € .
26	e, and	due to the cause	(s) and man	ner as stat	ed.

determined	building, etc. (Specify)					
	40 Spital					
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date						
2 Medical Examine	er: On the basis of examination and/or investigation, in my opinion, de					

on, in my opinion, death occurred at the time	
9c. License number	29d. Date signed (Month, Day, Year)

	/\4	1							
0.	Name and ad to	ss of	erson v	vho complete	d cause	of death	(Item 23a)	(Type,	Prin

WASHINGTON ADVENTIST HOSATAL M.D.

and manner stated.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar MD Certificate of Death Registrar MD, TCHD, 5/15/09 pha 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Month Marie Oney 05-10-2009 2:00A /Medical 4a. Facility Name (If not institution, give street and number) 240094b. City, Town, or Location of Death 4c. County of Death Examiner Ridgely er 1 Year | If Under 24 Hrs. Holsinger Lane Caroline 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) Funeral Days Hours 1 ☐ M 2 🛣 F Months 06-22-1926 Delaware 222-18-5919 Director 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show 1 ☐ Yes 2 No **Funeral Director** Caroline Ridgely Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be I 24009 Holsinger Lane 21660 USA Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 □ Divorced Black 'natural", Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Substitue Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Bradlev Oleiva Ellen Onev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathon Perkins / Salisbury, Md. 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Md. Veterans Cem. 05/15/09 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home Signature of Funeral Prvice Lice 717 W. Division St., Dover, De. 19904 Tassive 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, HYPERTENSION Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) ed by the a 9□Unknowr 9 Unknown page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 or Attending Physician: rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 2L No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the f 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 🕊 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number D0053815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

MAY 15 2009

32. Registrar's Signature

MARKET ST DENTON MD 2/629

			For State Registrar	State o	f Maryland / De		ment of H ficate of L		nd Me		iene eg. No.	200	9 16978
Million	Physici /Medi		1. Decedent's Name (First, Middle Catherine Mar	,		•			2.	Date of Deal Month May	h Day	Year 2009	3. Time of Death 7:30p M
	Examir		4a. Facility Name (If not institution, Williamsport			41	b. City, Town, or Willia					ounty of Dea	
	Funeral Director		214-14-6682	6. Sex 1 □ M 2 💢 F	7. Age (In yrs. last birtho	M	f Under 1 Year Ionths Days		Min.	Date of Birth (Month, Day) [arch ]	Year)	9. Bir C	rthplace (State or Foreign ountry) aryland
Marylan	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10c. Street and Number  154 Artizan Street  11. Marital Status  1 Never Married  15. Decedent  (Specify only highes  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, It  19a. Informant's Name/Relationsh  John Clopper — It  20a. Method of Disposition	eet    12. Was Decendary   12. Was Decendary   12. Was Decendary   13. Was Decendary   14. Was Decendary   15. Was Decendary	edent Ever in U.S. prces? 2 No ve ales:  16a. De (G fin Nu 1	3. Was If You accedentive kinder. DO	nsport 10f. Zip Code 2179 s Decedent of Hi es, specify Cuba Yes 2 No t's Usual Occupa d of work done of NOT use retired,	spanic Origin, Mexican, I Specify: ation luring most o  18. Mother's  Marg and Number	Puerto Ric of working s Name (F garet or Rural F	y Yes or No- can, etc.)  First, Middle, I  Marti  Boute Number	16b. Kind Ho Maiden S n Ro ; City or	Black, Whi  Specify:  In the door of Business  Spital  Surname)  Wland  Town, State,  Md. 2	erican Indian, ite, etc.  White  S/Industry  Zip Code)
Baltimore,	permit. Pages 1 Department of H Important: if ite any injury or ot once.		20a. Method of Disposition  1 Burial 2 MCremation  4 Donation 5 Other (Sp.  21. Signature of Femeral Service L	ecify)	State cemetery,	OWN 22. N	Cremate of ory or other place ame and Address E. Wil	ory 5/	14/09 Mi	9 1 nnich	Hage Fune	rstown ral Ho	, Maryland
•	hysician and hysician and hysician and private transit is the burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	caused the death. Do not each line.  (or as a consequence of):  (or as a consequence of):  (or as a consequence of):				V40 L				Approximate Interval Between Onset and Death Communication MONTIES
Box 6	death certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	nant at time of death		etopic pregnancy ther (specify)				23	3d. Date of de Month	elivery Day Year
rds, P.	quires that the de n signed by the s and be detached f	b	Part II. Other significant conditio	ns contributing to de	eath but not resulting in th	e unde	rlying cause give	en in Part I.		23e. Did tol			to the cause of death?  Probably 4 □Unknown
	: The law requires that the cate has been signed by the page 2 should be detache.	Completed								24a. Was a autops perfor 1 Yes	y I	24b. Were a prior to death?	autopsy findings available completion of cause of
Division or Vital	To the Hospital or Attending Physician: Th within 24 hours affect death.  To the Funeral Director: Affer this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1   Yes   250 No  27. Manner of Death  1 Natural 5   Pending investigation of the pendin	28a. Date (Monation of be 28e. Place	Inpatient 2 ER/Outpa of Injury th, Day Year) 28b. Tim Inju e of injury - At home, farm ing, etc. (Specify)	e of ry	28c. Injury Work M 1 \( \triangle \)	er: 4 X Nurs	sing Home 280	Check only on  5 Reside  d. Describe he  Location (Si City or Town	ence 6 bw injury	occurred	ecify) Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral Completely filled it	Medical Co	29a. Certifier 1 <b>% Certifying</b> (Check only one) 2 Medical B	xaminer: On the b	best of my knowledge, deasis of examination and/oner stated.	eath oc r inves	ocurred at the tim tigation, in my o	ne, date and pinion, death	place, and h occurred	d due to the c at the time, d	ause(s) a late and p	and manner a place, and du	as stated. ue to the cause(s)
•	To the vithing to the complex	Me	29b. Signature and title of certifier	we me	2		29c. License	number 700				signed (Mon	oth, Day, Year)
Q'	H-1 Sta	ite	30. Name and address of person vided Howe 31. Date filed (Month, Day, Year)	154 N	se of death (Item 23a) (Ty AIZTIZAL Registrar's Signature			Willi	AM	SPOR		MD	21795

MAY 14 2000 Janua A. Jakes ORIGINAL

State of Maryland / Department of Health and Mental Hygiene UU

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 9, 2009 7:00 a Raymond Rabin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 7501 Democracy Blvd. #314 Bethesda 8. Date of Birth (Month, Day, Year) March 27, 1917 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 X M 2 □ F New York 92 March Director 058-03-4890 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 1.2 should be filed within 72 hours after death with the Maryla. It and Mental Hygiene. 7 is marked other them "natural", or items 23a or 28a-f show fraumatic event, it is "selected." 1X Yes 2 No Director Bethesda Maryland Montgomery 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20817 USA 7501 Democracy Blvd. #314 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 □Yes 2 2 If Yes, Give Year or Dates: 2 **2** No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White 2 3 → Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government College (1-4or 5+) Elementary/Secondary (0-12) & Private Practice Lawyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Yanitz Samuel Rabin ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh
Department of Health and
Important: If item 27 is n
any injury or other traum
once. Crestview Court, Rockville, Maryland 20854 Carol Isen, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King David Meml Gdns 05/11/2009 |Falls Church, Virginia 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc.
1170 Rockville Pike, Rockville, Maryland 21. Sign fure of M01255 1170 Rockville Pike, Rockvil

23a. Part 1. Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 20852 Immediate Cause (Final Severe Aortic Stenosis 6 months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 6 months Ischemic Cardiomiopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, signed by the attending physician be detached for use as the burial Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 ☐Yes 2 ☐No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation o 24 hours after death.

E Funeral Director: Afterely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tipe of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Roger Stevenson, Jr 6410 Rockledge Drive, #200, Bethesda, Maryland 31. Date filed (Month, Pay, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Mary Virginia Richmond May 17, 2009 01:40A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown If Under 1 Year | If Under 24 Hrs. 11 West Baltimore St. Apt. 632 Washington Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Davs Hours 1□M 2**X** F Months 218-34-2733 71 Nov. 8, 1937 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r than "natural", or items 23a or 28a-f show 1 Yes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and Injury or other traumatic event, the Medical Experiment aust being once. 11 West Baltimore Street Apt. 632 21740 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify. 2 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 <u>Homemaker</u> Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patrick Brezler Anna Catherine Doyle Harry ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine A. Baker / Daughter 439 Carrolton Ave. Hagerstown Maryland 21740 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 5/21/2009 Williamsport, Maryland Greenlawn Cemetery of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Altrodelisotie **Physician** MINS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No ours after death.

leral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Hornicide 24 hours a 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hour To the Fune completely file Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 28365 30. Name and address of person who completed cause of (gath (Item 23a) (Type, Print)

MANZAR. 2SHAFI: 368 mul Heightaun MO 21740 nulls Street-31. Date filed (Month, Day, Year) 32. Registrar's Signature State BARLO

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Scott, S. 21:38 M 2009 Stephen 0 5 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hartord Harford nemorial Hospital Grace de Harre 8. Date of Birth (Month, Day, Year) Sept. 30, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Min. Days 1X M 2 □ F 71 1937 West Virginia 236-58-2853 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Express... ust be confined an once. 1 ∏Yes 2x XNo Director Maryland | Harford Havre de Grace 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21078 USA Funeral 2302 Nova Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★★No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1∐Yes 2√DKNo Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clova Snodgrass Euell ည Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2302 Nova Dr., Havre de Grace, MD 21078 Polly Scott (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 5/20/09 West Chester, PA R.A.Ferris & Co. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complet tions that or sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hemorrhause disease or condition resulting in death) /Medical Due to (or as a consequence of): 2 400 Examiner hemothoras Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 9 hus Exam thoracentesis Due to (or as a consequence of) certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 XYes 2 □ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2√2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this s after death. al Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Division of Vital Records, Hospital or Attending Physician:

within 2 To the

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMP filed (Month, Day, Year

MAY 27

50, MD 32. Registrar's Signature

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Ave HAURE de GRACE, MD 21078

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 7, 2009 **Physician** 11:30 am SUMBERG Ruth Mann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth June 16, 9. Birthplace (State or Foreign Year) 918 **Funeral** 1 □ M 2 🖔 F Months Days Hours New York 90 104-14-4264 **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Influiry or other traumatic event, its Medical Examination that is indiffed a ponee. 10a State 10b. County 1 □Yes 2 NO Director Montgomery Chevy Chase Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8100 Connecticut Ave 20815 U.S.A. Funeral 12. Was Decedent Ever in U.S. Aymed Forces?

1X Yes 2 No WWII If Yes, Give Year or Dates: WAC 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ۵ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Mendelson Joseph Henry Mann ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2700 Calvert St., NW, #214, Washington, DC 20008 19a. Informant's Name/Relationship (Type. Print) Steven Sumberg son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metropolitan Crematory May 8, 2009 Alexandria, VA d 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licens 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): unknown Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Myocardial Infarction Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ξ. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy performe 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 7, 2009 D0065720 cause of death (I 8600 01d Georgetown Rd., Bethesda, MD 20814 Iwanze, MD Rosemary 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 Registrar THERE

			For State Registrar	State of M	-	epartment of Certificate of		d Mental Hy	gieņe Reg. No. 2	09   698
	Physic /Medi		1. Decedent's Name (First, Midd Nancy Read	<sub>le, Last)</sub> Schaefer				2. Date of De Month MAY	7, Day 200	3. Time of Death 15:40 M
and and	Examir		4a. Facility Name (If not institution Prince George's	n, give street and number, Hospital Ce	enter	4b. City, Town, Cheve	or Location of De ${ m rly}$		ż	of Death e George's
	Funeral Director		5. Social Security Number 051-22-6039	6. Sex 7. Ag	ge ( <i>In yr</i> s. last birtho 80 Yr	Months Dave			1928	9. Birthplace (State or Foreig County) New York
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	ce George's	10c. City, Town of Silver					10d. Inside City Limits
	th with the 23a or 28 ast be not	Funeral Director	10e. Street and Number 3142 Gracefield	Road,MG502		10f. Zip Code 20904			10g. Citizen of V United	What Country?  States
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by	11. Marital Status  1 ☐ Never Married 2 ☒ Mar  3 ☐ Widowed 4 ☐ Divorced	If Yes Give	Ever in U.S. No	13. Was Decedent of If Yes, specify Cu 1 □ Yes 2 XNo		(Specify Yes or No erto Rican, etc.)	o- 14. Raci Blac Specify	e - American Indian, sk, White, etc. v: White
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, Mary	and 2 shore ealth and North and North 127 is mainer trauma		19a. Informant's Name/Relations Edward W. Schae		1 314		ld Road,		lver Spr	ing, Md. 20904
Baltimore,	0 0		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (5	3 □ Removal from State Specify)	20b. Place of D cemetery, Metropo	isposition (Name of crematory or other pla olitan Cre	matory 5		Alexand	City or Town, State
I	Physician		21. Signature of Pureral Se vice 23a. Part 1. Enter the disease, o shock, or liver tailure. List immediate Cause (Final disease or condition	r complications that cause	d the death. Do no ine.	22. Name and Addi Donald V. 4400 Powd t enter he mode of dy	ress of Facility Borgwar er Mill ring, such as card	dt Funer Road Bel	al Home, tsville, arrest,	PA Maryland 2070 Approximate Interval Between Onset and Death
	/Medical Examiner -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of	Filo	elle	tion	1	
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O. Box 6	the death certifii y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	e of pregnancy 2 ☐ Fetal death at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy			te of delivery nnth Day Year
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f Vita	Physician: T this certifical ral director, pa	To Be (	25. Was case referred to medical examiner?	Hospital:	ient 2 ☐ ER/Outp	atient 3 DOA	her:	eath (Check only		uer (Specify)
Division of	Ing Attel	Certification: 7	27. Manner of Death 1 Natural 5 Pendin 2 Accident investi 3 Suicide 6 Could 4 Demicide detern	28a. Date of Inj (Month, Da gation not be	ury 28b. Tin lnju jury - At home, farm	ıry Wo	□Yes 2 □ No	28f. Location	how injury occurr	red per or Rural Route Number,
Ö	Hospital or Attend 4 hours after death, Funeral Director; A tely filled in by the fi	cal Certi	29a. Certifier 1 Certifyi	building, e ng Physician: To the best Examiner: On the basis	tc. (Specify)  of my knowledge, of examination and/	death occurred at the	time, date and pl	City or To	e cause(s) and ma	anner as stated.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

ah (Nem 23a) (Type, Print) M.D. 3001 Hospital Drive Cheverly, Md. 20785 32. Registrar's Signature

pares

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar			il ylaria / =	Cert	ificate of L	Death	u	R	leg. No.	200	9 16	984
	Physicia	an.	1. Decedent's Name (Fire		-						Date of Dear Month	th Day	Year	3. Time o	
	/Medic		Helen	Ward	Sulliv	an	1				May		2009	2:00	P <sup>M</sup>
1	Examin	er	4a. Facility Name (If not 5480 Wiscon					4b. City, Town, or		eath			County of Dea		
<u> </u>			5. Social Security Number			(In yrs, last birt	_	Chevy Ch		Hrs. 8. [	Date of Birth (Month, Day		ntgome 9. Bir	thplace (State	or Foreign
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	ms 2%	nera	11. Marital Status		12. Was Decedent E	ver in U.S.	13. W	l as Decedent of H Yes, specify Cuba	ispanic Origin	? (Specify	Yes or No-	1		erican Indian,	
٥	be flied within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, Item Tradical Examinar must be notified at		1 Never Married		Armed Forces? 1 ☐ Yes 2 \(\overline{\Lambda}\) N If Yes Give	lo		res, specily Cuba □Yes 2XINo	Specify:	uerto nica	iii, etc./	I	Black, Whi Specify: Wh		
5-0036	ural",	d by	3 Widowed 4 □		If Yes, Give Year or Dates:	40-			ation				d of Business		
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פ	al Hyg othe vent,	Φ	17. Father's Name (First	, Middle, Last)					18. Mother's	Name (Fil	rst, Middle,	Maiden S	Surname)	-	
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Mar	2 should be and Mental is marked raumatic ev		19a. Informant's Name/					Address (Street						Zip Code)	
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n n	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		D 1/1/1	ng //	Brens			0 Wiscon							016
			23a. Part 1. Enter the di	sease, or comp	olications that caused	the death. Do r	not ente	r the mode of dyin	ng, such as car	rdiac or re	spiratory ar	rest,		Approxima Interval Be	ite etween
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	/Medical		resulting in death)		a. •	a consequence								7 - 7	
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	ie dea the at red fo	Physician/	in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ☐ Pregnant at 9 ☐ Unknown			Other (specify) _					Wichti	Day	Tour
J.	w requires that the de been signed by the should be detached		Part II. Other significan	t conditions of	ontributing to death bu	ut not resulting in	the und	derlying cause giv	en in Part I.		23e. Did to	bacco u	se contribute	to the cause of	death?
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S	w required	Completed									24a. Was	an	24b. Were a	autopsy finding	s available
Ř	12 22 20	dmc								_	autop perfoi	rmed?	prior to death?	completion of	cause of
<u>ra</u>		Φ	25. Was case referred to	o medical	1				26. Place of	Death (C	1 □Yes Check only o		1 □Ye	s z-Lino	
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🖺 No		Hospital: 1 ☐ Inpatie	ent 2 ER/OL	ıtpatient	3 ☐ DOA Oth	er: 4 🗆 Nursii	ng Home	5 ₹ Resid	dence 6	i □ Other (Sp	ecify)	
n of	ing Phys n. After this funeral di	L:uo	27. Manner of Death 1 Natural 5	☐ Pending	28a. Date of Inju (Month, Da	ry 28b. <i>y, Year)</i>	Time of njury	28c. Injur Worl	y at k?	28d	. Describe h	now injury	occurred		
Division	tendi eath. or: A the fu	catic	2 Accident	investigation Could not be					Yes 2 □ No	-				- 10	
Ž	or Att	ertification:	4 ☐ Homicide	determined	28e. Place of Inju- building, etc	ury - At home, fa c. <i>(Sp</i> ec <i>ify)</i>	rm, stre	et, factory, office		28f.	City or Tou	Street and vn, State)	d Number or i )	Rural Route Nu	mber,
_	spital ours a leral I	O	29a. Certifier 18	Certifyina Ph	ysician: To the best	of my knowledge	e, death	occurred at the fi	me, date and	place, and	d due to the	cause(s)	and manner	as stated.	
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	(Check only 2	Medical Exan	niner: On the basis o and manner sta	f examination ar	nd/or inv	estigation, in my o	opinion, death	occurred	at the time,	date and	place, and di	ue to the cause	(s)
	To th within To th comp	Me	29b. Signature and title	of certifier	1			29c. Licens	e number			29d. Dat	e signed (Moi	nth, Day, Year)	
	(I)		Vilso	moti	to			D516	16		1	May	6, 200	9	
	10		30. Name and address of						1000	<b>71</b>			D 000	1.5	
			Dr. Nelson 31. Date filed (Month, D			Wiscons ar's Signatur	_		1300, 0	Chevy	Chas	e, M	D 208	15	
	Sta Registr			v ny 21		a. s orginatur	ba	will.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [ ] [ ]

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		•	For State Registrar		, , , , ,	Ce	rtificate of L	Death	,	Reg. No.		, , ,		
	-		Decedent's Name (First, Middle	e, Last)					2. Date of De Month	eath Day	Year	3. Time of Death		
	Physici: /Medic			William L. S	impson				May	02	2009	6:20 p M		
	Examin		4a. Facility Name (If not institution	n, give street and num	ber)		4b. City, Town, or	Location of Deat	h	4c. Cou	nty of Death			
			Washington Ad	ventist Hospi	tal		Ta	koma Park			Montgom	ery		
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birthpla Countr	ace (State or Foreign		
	Director		008-01-9307	1 <b>x</b> M 2 □ F	91	L Yrs.			February		Ver	mont		
7			Usual Residence of Decedent		10a Ci	ty, Town or Lo	antion			10d. Inside City Limits				
2/2/2	shov	_	10a. State 10b. County		100. 01	ty, TOWITOT LC						1 □Yes 2 No		
W	Ba-f	Director		gomery				er Spring		10 011	of What Countr			
ŧ	or 2	Ö	10e. Street and Number				10f. Zip Code			rug. Cilizen				
÷	s 23a	ral	1014 Devere			0 140	NA Development of III	20903	Yanaifi Van ar Na	14	U.S.A Race - America			
r d	item	Funeral	11. Marital Status	12. Was Deced		.S. 13.	Was Decedent of H If Yes, specity Cuba	n, Mexican, Puer	to Rican, etc.)	14.	Black, White, et			
36	jo,	by F	1 ☐ Never Married 2 🖬 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	es: <b>1942-1</b>	1945	1 □Yes 2 X No	Specify:		Spe	ecify:	ucasian		
d 21215-0036 filed within 72 hours after death with the Maryland	tura			t's Education		16a. Dece	edent's Usual Occup	ation		16b. Kind o	f Business/Indu			
: 15 2 2 3	n "n	Completed	(Specify only highe	st grade completed)	40r F . \	(Give	kind of work done of DO NOT use retired	turing most of wo. ()	rking					
212	r tha	E O	Elementary/Secondary (0-12)	College (1-	401 5+)		Budget Ana	ılyst		G	overnment	<u> </u>		
ק י	othe ent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	e, Maiden Sun	name)			
<u>a</u>	Aenta Aenta rked tic ev	To E	Alfred C	. Simpson					Catherine	F. Lit	tlejohn			
ary	and A	_	19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Street	and Number or R	ural Route Numb	oer, City or To	wn, State, Zip (	Code)		
Š	alth a		Helen Simpson -	Spouse		1014	4 Devere Dri	ve, Silve	r Spring,	Marylan	d 20903_			
e e	othe other		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place	e)	Date	20c. Locati	on - City or Tow	n, State		
E Company	nt: If		1 ☐ Burial 2 🗷 Cremation 4 ☐ Donation 5 ☐ Other (5		tate	-	oln Cremator	i i .	6/2009	Brent	wood, Mar	yland		
Baltimore, Maryland 21215-0036	perfilt. I agos I and 2 Should be most main re-thous and board main around your linguistics. I had the and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. M. Mcdical Evanination must be notified at once.		21. Signature of Fur eral \$\frac{1}{2} rvic	1	11 //	2	2. Name and Addre	ss of Facility	1 11 Y					
ä	S E E S		> VII Need	PIVE	twe	2	Hines-Rinal				ring, Mar	ryland 20904		
			23a. Part 1. Enter the disease, o	complications that ca	used the dea	th. Do not en						Approximate Interval Between		
a. P	hysician		shock, or healt failure. List									Onset and Death		
	/Medical		disease or condition resulting in death)	a	<b>umonia</b> or as a consec	quence of):								
E	xaminer			Нур	otension	1								
		ne.	Sequentially list conditions, if any, leading to immediate	Due to (c	or as a consec	quence of):								
9	nd ansil	Examiner	Cause (Disease or injury that initiated events	с. Нур	oxia									
o,	an ar rial-t	ă	resulting in death) Last	Due to (d	or as a consec	quence of):								
of Vital Records, P.O. Box 68760, Charician The law conjugation to be executed	physician and the burial-transit	Medical		d										
9	ing pl	Med	IF FEMALE:	1										
Box	tendi		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	ome of pregri irth 2  Fet		☐ Ectopic pregnanc	y		23d	Date of deliver Month	ry Day Year		
О. В	he at ed fo	sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregn 9 ☐ Unkno	ant at time of	death 5	Other (specify)				WIGHT	Juy Tour		
٩. إ	igned by the attendir be detached for use	Physician/	9 Unknown	19.6.		- Min - In Man		en in Dout I	220 Did	tobacco use	contribute to the	e cause of death?		
<u>က်</u> ခွ	signe signe	þ	Part II. Other significant condition	-	ath but not res	sulling in the t	andenying cause giv	en in Fait i.				ably 4 🗆 Unknown		
Orc	s peen si	Completed	Acute Mental Sta	itus Changes										
ec	has b	鱼	Dementia						24a. Was	opsy	prior to con	osy findings available npletion of cause of		
H 2	ate l	등	Acute Renal Fail	ure					pen 1 □ Yes	formed? 2 <b>⊠</b> No	death? 1 □ Yes	2 □ No		
/ita	ertific sctor,	Be	25. Was case referred to medica examiner?				I ou		ath (Check only	one)				
) + (	this c		1 ☐ Yes 2 😿 No		<u> </u>		ent 3 □ DOA Oth	4 L Nursing	Home 5 ☐ Res			)		
ב ב	After	ë.	27. Manner of Death 1   Natural 5 □ Pendi	ig ,	h, Day, Year)	28b. Time of Injury	Wor	k?	28d. Describe	how injury of	ccurred			
Sio	eath.	cati	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	gation not be				Yes 2 □No	006 Leasties	(0)		I Davida Numbar		
Division of Vital Records,	irect irect n by	Certification: To	4 Homicide determ	nined 28e. Place buildir	of Injury - At h ng, etc. <i>(Spec</i>	nome, farm, st ify)	treet, factory, office		28f. Location City or To	(Street and N own, State)	umber or Hural	l Route Number,		
1					host of multi-									
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. Lil														
4	ithin (	Med	29b. Signature and title of certific		ioi sialeu.		29c. Licens	e_number		29d. Date s	igned (Month, L	Day, Year)		
DS9284							29d. Date signed (Month, Day, Year)							
	istl		30. Name and address of person		a of death (Ita	m 23a) (Tuno	Print)	,		1				
			Shahid Shamim, I					a Park. Ma	rvland 20	912				
	Sta	ite	31. Date filed (Month, Day, Year		egistrar's Sign				J					
	Pogiat	rar	MAN AN	2009 /2.	una d	1. 100	Willes.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MELVIN **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Dea **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Hours **Funeral** Months Days 1 **X**M 2 □ F 82 Jan 5, 1927 Maryland 215 22 6481 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show Examiner must be notified at 1 Yes 2X No Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number ō 21043 United States or items 23a 4926 Alice Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1₺ Yes 2 □ No If Yes, Give Year or Dates: 1949–50 14. Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 🔀 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 ner than "natural", o 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Sub Shop 10 Owner. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Warren Santmyer Myrtle Wolfe ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4926 Alice Avenue Ellicott City, MD 21043 Grace M. Santmyer/Wife injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If Ite any injury or of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Ardent Crematory 5-15-2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical infarction Examiner Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes 2 🗌 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No ieral Director; Af 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Jiehelle Zikusoka, MD KES - 000 2009

(04) State

ZIKUSOKA, Michelle

MAY 12 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

31. Date filed (Month, Day, Year)

Registrar

			For State Registrar	State o	of Marylan		artment o		ealth and M Death		giene Reg. No.	09	16987
	Dhuoinic		1. Decedent's Name (First, Middle, La							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		JACQUELYN A	MN	SHORB					MAY		2009	10:50A M
0	Examin		4a. Facility Name (If not institution, given	re street and nu	ımber)				Location of Death		4c. Cou	nty of Death	
			2421 Bel Pre Ro						r Spring			ontgom	
	Funeral			Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs.	last birthday) Yrs.	Months D	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	, Year)	9. Birthp	place (State or Foreign
	Director		218-34-5065 Usual Residence of Decedent		71	115.				Sept. 2	2 1937	Wash	ington,D.C.
	and	ŀ	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	Od. Inside City Limits
	Maryl 1 sho led a	ō	Md. Montgo	mery	S	ilver	Spring						1 ☐ Yes 2 No
	the 28a	rec	10e. Street and Number		1		10f. Zip Co	ode			10g. Citizen	of What Cour	ntry?
	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-1 show he Mcdical Examiner is ust be notified at	Funeral Director	2421 Bel Pre Ro	ad					20906		Unit	eđ Sta	tes
	ms 2	Jera	11. Marital Status		cedent Ever in U.	.S. 13.	Was Deceder	nt of Hi	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No	14. [	Race - Americ	
ဖွ	after or Ite	교	1 ☐ Never Married 2 Married	Armed F 1 Tyes If Yes, G	2 No		1 ☐ Yes 2.2		Specify:	nican, etc.)			
903	rel',	d b	3 Widowed 4 Divorced	Year or I	Dates:		103 2,2					ocify: Whi	
5-	d within 72 ho giene. er than "natur the M. dical E	Completed by	15. Decedent's E (Specify only highest gr		)	16a. Dece (Give	dent's Usual ( kind of work	Occupa done d	ition luring most of worki )	ing	16b. Kind o	f Business/In	dustry
12	within ne. than	m du	Elementary/Secondary (0-12)	-	(1-4or 5+)		ptioni				Man	tal He	alth
2	filed v Hygie other t		12 17. Father's Name (First, Middle, Lasi	0		Nece	PCIONI	.5 L	18. Mother's Name	(First, Middle.			artii
ano	d be	) Be	Clarence Emers		back					Bern			
Maryland 21215-0036	should Ind Men	2	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	na Address (S	Street a	and Number or Rura	i Route Numbe	r, City or To	wn, State, Zip	Code)
∑	s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than other treumetic event, the M		Hubert H. Shorb		<b>Husb</b> and				Road, Si				20906
Baltimore,	s 1 al if Hea item othe		20a. Method of Disposition			Place of Dispo	osition (Name matory or othe	of ar place	a)   [	Date	20c. Location	on - City or To	own, State
Ę	permit. Pages Department of t Important: If ite eny injury or of		1 Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Speci		State	-	ille U			2/09	Burt	onsvil	le, Md.
alti	mit. partin sorta / inju		21. Signature Funeral Service Lice	hse		22	2. Name and	Addres	s of Facility Barber I	Superal	Home		
m	Depa Impo eny ir		John lun	to 1	11-009				x 5038, I			Md.	20882
	4.0		23a. Part. Enter the disease, or con shock, or heart failure. List only	plications that	caused the deat								Approximate Interval Between
	Physician	8 1	Immediate Cause (Final disease or condition			LEUKEM	IIA						Onset and Death One Month
9	/Medical		resulting in death)	a Due to	(or as a conseq							1	
	Examiner		Sequentially list conditions.	b									
	P #5	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or mjury	Due to	(or as a conseq	uence of):							
	and and I-tran	хаш	that initiated events resulting in death) Last	c	(or as a conseq	uence of):							
760,	te be executed ysician and e burial-transit	aiE		300.0	(0. 40 4 05.1004	23.133 3.7.							
687	2 2 2	2		_ d			-				-		
×	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregna	ancy					23d.	Date of delive	erv
Box	death atter	ciar	in the past 12 months?	4□Preg	birth 2 ☐ Feta nant at time of d		⊒Ectopic preg ⊒ Other (s <i>pec</i>					Month	Day Year
P.O.	at the de by the a	hysi	9 Unknown	9□ Unki	nown								
	2 2 B	by P	Part II. Other significant conditions	contributing to	death but not res	ulting in the u	inderlying cau	ise give	en in Part I.	23e. Did to	obacco use o	contribute to t	he cause of death?
ğ	w require been sig should b									10	′es 2□N	o 3∏Proi	bably 4 Mnknown
၁၁	law requ	ompleted								24a. Was		4b. Were auto	opsy findings available impletion of cause of
ĕ	The law cate has page 2 s	Com								perfo 1 ☐ Yes	rmed?	death? 1 ☐ Yes	2□ No
ita	Physicien: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?						26. Place of Death				
<u>~</u>	Physic this corral dire	2	1 ☐ Yes 2 🗷 No		Inpatient 2				ar: 4 🗆 Nursing Ho				fy)
ū	ding P h. After t funera	iuo!	27. Manner of Death 1 Natural 5 ☐ Pending		of Injury nth, Day Year)	28b. Time o Injury		Work	(?	28d. Describe I	now injury oc	curred	
Sic	or Attending ifter death. Director: After in by the fune	icat	2 Accident investigate 3 Suicide 6 Could not l	DB DIS	o of Injury At h		M		Yes 2□No	29f Location /	Stroot and M	umbor or Pue	al Route Number,
Division of Vital Records,	or All	ertification;	4 ☐ Homicide determined	build	e of Injury - At he ding, etc. (Specif	y)	reet, ractory, o	опісе		City or Tox		umber of Aut	ar noble learnoor,
	spitel ours lerel filled	0	29a. Certifier 1 Certifying P	hysicien: To th	ne best of my kno	wledge, deat	th occurred at	the tim	ne, date and place,	and due to the	cause(s) and	i manner as s	stated.
	8 Hos 24 h 8 Fur etely	edical	(Check only 2 Medical Exe	miner: On the	basis of examina nner stated.	ition and/or in	vestigation, in	n my op	oinion, death occurr	ed at the time,	date and pla	ce, and due t	o the cause(s)
_	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	1	7011	100	29c. l	License	number		29d. Date si	gned (Month,	Day, Year)
				11	MU	SLIF	(D)	()	226 86		LUN	8	2009
	5		30. Name and address of person who	completed cau	use of death (Iter	п 23а) (Туре,	, Print)			L		7 7	20022
KB_	_		Kenneth Miller					Lip	Dr., #32	/, Olne	y, Mar	yrand 	20832
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature	arked						
	Registr	ar	MAY 112	000	6								

			1 - For State Registrar	Otate of Ma	Cei	tificate of L			g. No. 2 ()	09	16981
П	Physici		1. Decedent's Name (First, Middle, La <b>KENN</b> E	<sup>st)</sup> TH M. SEYM	OUR			2. Date of Death Month MAY	_	Year 009	3. Time of Death 7:20 P M
	/Medic Examir		4a. Facility Name (If not institution, given 3476 ALBANTOWN	,		4b. City, Town, or EDGEWO	Location of Death		4c. County o	of Death	DRD
	Funeral Director		5. Social Security Number 6. S 218–46–7685	Gex 7. Age	(In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JUNE 5,	Year) 1949	9. Birthpl Count	ace (State or Foreign try) TLAND
	yland now		Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or Lo	cation				10	d. Inside City Limits
	e Mar	Director		FORD		EDGEWO	OD				1X Yes 2 No
	th with th	al Dire	10e. Street and Number  3476 ALBANTOWN	E WAY		10f. Zip Code	21040	10	g. Citizen of W UNIT		•
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventre must be redified at once.	by Funeral	11. Marital Status  1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1Yes 2 N If Yes, Give Year or Dates:	0	Was Decedent of H f Yes, specify Cuba I □Yes 2 Mo	ispanic Origin? (Spe un, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		- America , White, e	tc.
15-0	n 72 ho "natu edicel	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of workir	ng 10	6b. Kind of Bus	siness/Ind	ustry
212	d withii giene. er than	Somp	Elementary/Secondary (0-12)	College (1-4or 5- 5+	SUPERV		TY CULTUR	AL DIVER	RSITY	PUBI	LIC SCHOOL
Maryland	uld be file Mental Hy arked othe	To Be (	17. Father's Name (First, Middle, Last RUSSELL CAMPER,				18. Mother's Name DOLORES I			e)	
2	and 2 sho ealth and n 27 is mo		19a. Informant's Name/Relationship SHARON SEYMOUR /		I		and Number or Rura		-		
ore,	Pages 1 and nent of He int; If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disposemetery, cren				0c. Location - 0	,	
Baltimore,	nit. Par partmen ortant; Injury		4 Donation 5 Dother (Speci 21. Signature of Funeral Service Lice	fy)	HARFORD M					EN, M	1ARYLAND
B	permit. Departr Importa any Inju	u	1 Plantice	tt-Cole	man	LISA SCO 552 LEWI	ss of Facility TT FUNERA S STREET,	L HOME, HAVRE	P.A. E GRACI	E, MI	21078
1	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	nulliple	er the mode of dyin	ig, such as cardiac o	r respiratory arres	st,		Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions	Due to (or as a	rultiple	mue	lone				Tycer
,0,	icate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):	J					
68760,	icate by physici the bu	Medical		d							
O. Box (	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the line of the li	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	у		23d. Date Mor	e of delive	ry Day Year
s, P.	es that igned by be deta	by Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contri	ibute to th	e cause of death?
Records,	w require been si should b							1 □ Yes	1		ably 4 ☐ Unknown
al Rec	: The law cate has page 2 s	Completed						24a. Was an autopsy perform	i n	Vere autor rior to cor eath? □Yes "	osy findings available npletion of cause of No
Vital	Physician: Th r this certificate ral director, pag	9 Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 MNo	Hospital:	nt 2 ☐ ER/Outpatien	• 3 🗆 DOA Othe	26. Place of Death				
of	ding Phys h. After this funeral di	on: To	27. Manner of D ath	28a. Date of Injur (Month, Day		28c. Injury		ne 5 Resider 28d. Describe how			7
Division	Atten deatl ctor: y the	Certification:	Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	n	rv - At home, farm, stre	M 1 □'	Yes 2 □No	28f. Location (Stre City or Town,	eet and Numbe State)	er or Rura	Route Number,
	To the Hospital or , within 24 hours after To the Funeral Dire completely filled in b		(Check only 2 Medical Exa	nysician: To the best o	f my knowledge, death	n occurred at the tir	me, date and place,	and due to the ca	use(s) and ma	nner as si	tated.
	To the I within 2. To the I complet	Medical	29b. Signature and title of certifier	and manner state	ed.	29c. License	e number		d. Date signed	(Month, l	
			30. Name and address of parces who	completed source of de-	ath (Itom 23a) (Tune I		912		5/10	2101	
	(0		30. Name and address of person who VENKATA J. PARSA	, M.D., 60	2 <b>S.</b> ATWOO	D ROAD, S	SUITE 200,	BEL AIR	, MARYI	LAND	21014

Registrar

State

MAY 13 2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Drewn A. Sparks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician Lagrolyn Stone 9:30 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖾 F 218-24-0757 78 Vrs Director December 27,1930 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Expreiner must be notified at 1⊠Yes 2 No Directo Maryland Prince George's Colmar Manor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō USA 20722 3604 39th Avenue items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Loan Processor Loan Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Dare Edith Fern Nichols traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. 3604 39th Avenue, Brentwood, MD 20722 Tracy Stone / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland 5/15/2009 Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INEUMONIA /Medical Due to (or as a consequence of): Examiner INFECTION URINARY TRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Npatient Certification: To 28b. Time of Injury

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760. P.0. Division of Vital Records,

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending

investigation 6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) heverly mo 32. Registrar's Signature State Registrar

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

09-03802 Bonita Louise S	•	Otato of Marylana / Dopa	delible Ir rtment of tificate of	Health and Mental	Hygiene	2009 16
Physici		Registrar  1. Decedent's Name (First, Middle,Last)	uncate or	Death	Re 2. Date of Death	g. No. 3. Time of Death
Medical Exam		Bonita Louise Spencer			Month May 12, 20	Day Year 0635 hrs
		4a. Facility Name (if not institution, give street and number) Route 51	4	b. City, Town, or Location of Do Oldtown	eath	4c. County of Death Allegany
Funeral		Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birt	h(MM/DD/YYYY) 9. Birthplace (State or F
Director		213-64-8999 1 M 2xF	55 Yrs.		Min. April	1, 1954 Maryland
		Usual Residence of Decedent				Land Landa Ohal
w any		10a. State 10b. County 10c. City,	Town or Locati	on		10d. Inside City L
/land -f sho	tor		w Paw	10f. Zip Code	10	ng. Citizen of What Country?
r 28a	Director	10e. Street and Number 233 Amelia Street		25434		USA
death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.	S 13 Wa	s Decedent of Hispanic Origin?	( Specify Yes or No-	
eath w items ust be	Funeral	1 Never Married 2 Married Armed Forces?		es, specify Cuban, Mexican, Pu		White, etc.
filer d		3 Widowed 4 X Divorced If Yes, Give Year	1	Yes 2 X No specify:		Specify: Black
ours a atura xamir	d by	15. Decedent's Education (Specify only highest grade completed)		t's Usual Occupation (Give kind ost of working life. DO NOT use		16b. Kind of Business/Industry
16 n 72 h isan "n ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			, , , , , , , , , , , , , , , , , , , ,	Manufacturing
Withing giene.	om	12 17. Father's Name (First, Middle, Last)	Seams		ame (First, Middle, N	Manufacturing  Maiden Surname)
e filed al Hy nt, the	Be C	Tommy Smith			gie Frazi	
212 ould by Ment mark	To E	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (Street and Number	or Rural Route Num	ber, City or Town, State, Zip Code)
MD 12 sho th and 17 is		Gilbert L. Spencer				Virginia 25434
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once.			Place of Dispos crematory or oth	ition (Name of cemetery, ner place)	Date	20c. Location - City or Town, State
Pages nent o aurt:		4 Donation 5 Other Specify: Can	mp Hill	Cemetery 5	/17/2009	Paw Paw, West Virg
Salti ermit. epartn nport		21. Signature of Funeral Service Licensee				neral Home
		23a. Part I. Enter the disease, or complications that caused the death	18	8 Mosser Avenu	e Paw Par	w, West Virginia est.shock.orheart Approximate In
Physician /Medical		failure. List only one cause on each line.		no mode of dying, sacin do care	ac or roophatory arr	Between Onse Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a Head and Neck Injuries  Due to (or as a consequence of				
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate Due to (or as a consequence of	f):			
	cam	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of the co	f):		<del>.</del>	
executed an and al - transit		d				
760, icate be exe	dic	UNPENDED AMENDED				
Box 68760 death certificate b the attending physi	cian/Medical	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of preg		etal death 3 Ectopic pr	eanancy	23d. Date of delivery  Month Day Yea
Ox 687  eath certific  attending p	ciar	past 12 months?  4 Pregnant at time of de	onth	etal death   3Ectopic pr her <i>(Specify)</i>	egnancy	Widthal Bay
Boy e death the att	Physi	1 Yes 2 No 9 V Unknown 9 Unknown				
rds, P.O. B requires that the d been signed by the hould be detached	by P	Part II. Other significant conditions contributing to death but not r	esulting in the o	underlying cause given in Part I		bbacco use contribute to the cause of deat 2 V No 3 Probably 4 Unkr
S, P uires t n sign d be c				· · · · · · · · · · · · · · · · · · ·	_	
cords, law requir has been s	Completed				24a. Was	prior to completion of cause
Rec The la cate h	E				1 ✓ Yes	rmed? death? 2 No 1 ✔ Yes 2 1
tal Re(ician: The certificate	Be C	25. Was case referred to medical examiner?		26.Place of Death (Ci	neck only one)	
Vit hysic this all dire	10 E	1 ✓ Yes 2 No	ER/Outpatient		lursing Home 5	Residence 6 Other: Scene
ion of tending Pheath. tor: After the funeral		27. Manner of Death  1 Natural 5 Pending FOWND: Day, Year)	28b. Time of FOUND:	Injury 28c. Injury at Work?	Driver of mo	how injury occurred otor vehicle that overturned
IVISION or Attenu after death Director:	cati	2 ✓ Accident Investigation May 12, 2009	0605 hrs_	et, factory, office building, etc.	112212	Street and Number or Rural Route Numbe
Division of Vital Records, pital and retending Physician: The law requiremental end ours after death.	Certification:	Suicide Could not be determined (Specify) Local Stre		ot, ractory, office building, etc.	or Town, S	
ing St.		29a. Certifier		rred at the time, date and place		
To the Hos within 24 h To the Fm	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.				
T iv	Me	29b. Signature and title of certifier	-	29c. License number		29d. Date signed (Month, Day, Year)
		( DURDNADOO		O.C.M.E.		May 13, 2009

State Registrar OCME 2006

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

DOME

Carol Allan, MD Assistant Medical Examiner

31. Date filed (Month, Day, Year) MAY 27 2009

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 05 Year Physician 1058 Summerfield 19 Glavis /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegani Braddock Campus umber land WMHS-If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Mar 31, 1940 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min. Hours 1 🗆 📈 2 🗆 F Months 215-36-9243 69 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nutified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State WV Ridgeley Mineral 1 ☐Yes 2 ☐XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26753 USA Rt. 4 Box 11 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 Pes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ **X**o If Yes, Give Year or Dates: Specify: Specify: ð white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **PPG Industry** Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar Summerfield Rachel (Davis) Summerfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 4 Box 11 Ridgeley WV 26753 19a. Informant's Name/Relationship (Type. Print) Rt. 4 Box 11 wife Ridgeley Ruth Summerfield 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Ofernation 3 ☐ Ren oval from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Scarpelli Funeral Home, P.A. 5/15/20d9 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Carpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Peri 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only in cause on each line. ute cardiopulmonary Arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner COLOUCE ar teru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Dolmanary 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and tife 29d. Date signed (Month, Day, Year) 29c. License number D0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue Comberland, Med 21502

DHMH 17 Rev 1/2001 DIC

Registrar

DR. SUNIL GUPTA

31. Date filed (Month, Day

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Herman Charles Tremper M 0 2009 0446 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cecil Port Deposit 10 Daisy Lane Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 220-34-5034 Nov. 29, Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show dieal Exemitrer mast be notified at 1 □Yes 🌂 □ No Director Port Deposit Cecil Maryland 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number 10 Daisy Lane 21904 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iten ury or other traumatic event, in a Medical Examination 1 MYes 2 No If Yes, Give Year or Dates: 1961-64 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes XX No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Harbor Tunnel Elementary/Secondary (0-12) College (1-4or 5+) Tow Truck Driver Baltimore, Maryland Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Wilke Herman H. Tremper ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Daisy Lane, Port Deposit, Maryland Ethel K. Tremper 20c. Location - City or Town, State West Chester, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ferris & Co., Inc. Department o Important: If any injury or R.A. Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Control Home, Lee A. Patterson & Son Funeral Home, 21. Signature of Funeral Service Licensee Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmonary Immediate Cause (Final hrouic **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed the burial-trar resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 5 Pending investigation 1 Natural ours after death.

neral Director: A'
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2

4+1VA

31. Date filed (Month, Day, Year) State MAY 13 2009 Registrar

29b. Signature and title of certifier

32. Registrar's Signature

W High

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101

NON.

DHMH 17 Rev 1/2001

29c. License number

30047471

Elkton un 2/92)

29d. Date signed (Month, Day, Year)

May 12th, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 02:37 Taraving Ø5 6 2009 Armando /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hartond Harre de Grace Hartord memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | 0 8 9 17 3 7 9 7 8 9. Birthplace (State or Foreign **Funeral** Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exeminar must be notified at 1XYes 2 ☐ No Director Maryland | Harford Havre de Grace 10g. Citizen of What Country? United States 06 America 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or is marked other than "natural", or items 23a or is any injury or other traumatic event, the Modified Exeminal front both once. 21078 608 Labayette Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Specify: White 1 □Yes 2 🛣 No Maryland 21215-0036 Specify: 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)

Painter Civil Service Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Angela Vincenti 17. Father's Name (Eirst, Middle, Last) Armando Tarquini Be 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zin Code), 608 Lafayette Street Havre de Grace Maryland 21078 19a. Informant's Name/Relationship (Type. Print) Michael Tarquini (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Mt. Erun Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/20/2009 Havre de Grace, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service License 123 S. Washington Street, Havre de Grace, MD21078 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disea of or complications that caused the shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 ☐No P.O. the 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 ☐Yes 2 🗷 No 1 □Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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DHMH 17 Rev 1/2001

Barker

32. Registrar's Signature

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ARGUIMI, ARMANDO

09-03881 Roosevelt Taylor	
Physician Medical Examine	r
2 hours after death with the Maryland  "natural", or items 23a or 28a-f show any  LExaminer must be notified at once.	ted by tallelal bilease

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	ace of the field	Cert	ificate of	Death		_	Re	g. No.	201	15	69
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dical Examir		4a. Facility Name (if not institution	Roosevel			o. City, Town, or I	ocation of		May 15, 20		ty of Death	1020 1110	
		4a. Facility Name (if not institution 38 Arbutus Street	i, give street and numbe	er)	41	Elkton	Location of	Death		Cecil	.,		
Funeral			6. Sex 7. A	age (In yrs. las	st birthday)	If Under 1 Year			8. Date of Birt	h (MM/DD/YY	YY) 9. Birt	hplace (State or untry)	r Foreign
Director		233-58-8679	1 X M 2 F	71	Yrs.	Months Days	Hours	Min.	June 13	3, 1937		st Virg	inia
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5-0036 led within 7 Hygiene. other than the Medica	Com	9 17. Father's Name (First, Middle,	Last)		One				irst, Middle, I				
D 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "natural", natic event, the Medical Examine.	Be	John Taylor							Justice				
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ore, MD 21215-0036 s. I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho her traumatic event, the Medical Examiner must be notified at once		Lisa Gregson/I 20a. Method of Disposition	)aughter	20h F		Old Elk	metery.		Date			921 Town, State	
Baltimore, MD 2  Department of Health and I  Important: If item 27 is n  Injury or other traumatic		1 Burial 2 X Cremation	n 3 Removal from	State c	rematory or oth	er place)	_ ^	May		1 .,	. 01	T	D.A.
timent ritment y or o		4 Donation 5 Other Sp 21. Signature of Funeral Service		R. A	A. Ferris	& Co., I	nc.	2009		Wes	t Une	ester, I	A
Baltimore, MI permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum:	(0	16 to the H	/ (11)		Hi	ame and Address CKS Home 3 W. Sto	for	Fune Str	erals, reet. E	P.A. Ikton.	MD	21921	
Physician		23a. Part I. Enter the disease, or	complications that caus	ed the death.	Do not enter th	ne mode of dying,	such as ca	ardiac or r	respiratory arr	est, shock, or	heart	Approximate Between Or	
Medical kaminer	i	failure. List only one cause Immediate Cause (Final disease	Limortopolyo	Atheroscle	erotic Cardi	ovascular Dis	sease					Dear	th
tanime		or condition resulting in death)	Due to (or as a co	nsequence of	):							1	
	er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	nsequence of	):								
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	IF FEMALE:	23c. If yes, out	come of pregr	nancy						te of deliver		
Sox 687 leath certific e attending p for use as t	sician/	23b. Was decedent pregnant in t past 12 months?		n t at time of de	=	tal death 3 her (Specify)	Ectopic	c pregnan	icy	Mont	.h	Day \	Year
Box e death c the atten ed for us	ıysic	1 Yes 2 No 9 Un		1	3 01	ner (Specify)							
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Divis	erti	Odicide	ermined (Specify)						or rown,	State)			
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To the Howithin 24 h To the Fur	Medical	one) 2 Medical Example 29b. Signature and title of certification of the control of the certification of the certif	and manner stat	ed.			se number		amo, date			lonth, Day, Year,	)
	2	29b. Signature and title of certific	1/ 11 24				.M.E.			May 16		- , , , . 3 ,	
		30. Name and audress of perso	na.(/, ML)	of death (Item	23a)					1			-
		Pamela E. Southall, I				11 Penn Stree	et, Baltin	nore, N	1D 21201				
	tate			strar's Signati	ure &	asked							
Regis	Trail		7 2000 /2	RMARI	250	SENEZ							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:50AM Tressler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 41100 remorial Campus 940 la 9. Birthulace (State of Foreign If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 16, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Hours Months Days 1 □ M 2 □ F MD 215-74-5530 78 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinat must be notified at Oldtown MD Allegany 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21555 USA 18207 Wagner Road SE Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛪 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ≥ 3 X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dayton M. Lewis Martha E. Duckworth Lewis ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18201 Wagner Road SE Oldtown MD 21555 Department of Health ar Important: If item 27 is any Injury or other trau once. John Tressler son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/20/2009 Rocky Gap Veterans Cemetery MD Flintstone 4 ☐ Donation \_5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Fun al Servi x Licen ee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed 2√No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2√2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation of the total Director: Affected filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Op/the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier within 24 ho

To the Fune

completely f (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 18 2009 36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seton rumberland, Manyland Pomai 924

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

A. bark

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		1	For State of Maryland / Department of Health and Certificate of Death	ivieii		g. No.		
			Registrar  1. Decedent's Name (First, Middle, Last)		ate of Death	20	19-9	3. Time of Death
	Physicia		Clyde Wachter Unglesbee	Ma	Month	Day 8	Year 2009	1:10 P M
	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De		~		nty of Death	
	Examin	er	6001 Muncaster Mill Road-Casey House Rockville			M	ontgon	nery
_	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year   If Under 24 H	rs. 8. D	ate of Birth Month, Day,			place (State or Foreign
	Director		214-12-7545 12 M 2 F 89 Yrs. Months Days Hours Mi		in. 31			yland
	σ	- H	Usual Residence of Decedent					10d. Inside City Limits
	rylan		10a. State 10b. County 10c. City, Town or Location  Md Montgomery Brookeville				Ì	1X Yes 2 □ No
	e Ma Ba-f s	cto	ria: Honogomory		140	- Olainan	of What Cou	
	or 2	Director	10e. Street and Number 10f. Zip Code		10			
	ath w	<u>ra</u>	20 High Street 20833	/C===i6./	v/a a ar No		ted St	
	tems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Puttern Company (1997)	erto Ricai	n, etc.)		Black, White,	
36	s afte		1 □ Never Married 2 Married 1 MaYes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: WWII 1 □ Yes 2 Mar No Specify:			Spe	cify: Wh	nite
윽	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Evantral remarks and filed at	Completed by	15 Decedent's Education 16a, Decedent's Usual Occupation		1	6b. Kind of	f Business/Ir	ndustry
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<u>a</u>	uld be Jentz rked tic e	70 E	CTATERICE W. ORGEODOC		lachte			
ar)	12 should be filed within 7 th and Mental Hygiene. 7 <b>Is marked other than</b> " traumatic event, the Med	1	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or					
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ore	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items it raumatic event, the Medical Examination and the confilted at	l	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)	Date	2	20c. Locatio	on - City or T	own, State
<u>Ĕ</u>	Pag ment ant: I ury o		4□Donation 5□Other (Specify) Metropolitan Crem. ; 5	/14/0	)9	Alex	andria	a, Va.
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signifure if Fundal Service License / 22. Name and Address of Facility  Muriel H. Barbo	er Fu	neral	Home		
<u> </u>	20 E # 9		10 h 1 Van w m - 00410 P. O. Box 5038	8. La	avtons	<u>ville</u>	, Md.	20882 Approximate
			23a. Payl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card splock, or heart failure. List only one cause on each line.	diac or res	spiratory arre	est,		Interval Between Onset and Death
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J	/Medical Examiner		resulting in death)  Due to (or as a consequence of):					
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æ	The law cate has b	E			perforr	ned? 2 X No	death?	2 □No
ital		a l	25. Was case referred to medical 26. Place of	Death (C		e)		
of Vital Records,	S	0 8	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursin	ng Home	5 🗆 Reside	ence 6 🔀	Other (Spec	cify) Hospice
0	iding Phy Ih. After thi funeral (	Ę.	27. Manner of Death 1 Natural 5 □ Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?	28d.	Describe ho	ow injury oc	ccurred	
Ö	Attending ir death. ector: After by the funer	atic	2 Accident investigation M 1 Yes 2 No					
Division	or Att ter de irecta n by t	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (St City or Town	reet and N n, State)	umber or Ru	iral Route Number,
Ω	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	place and	due to the o	allee(e) an	nd manner a	s stated.
	Hosp 24 ho Fune Fune	ica	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and process of my knowledge, death occurred at the time, date and the time, d	occurred	at the time, d	ate and pla	ace, and due	to the cause(s)
	the thin the the thin	Medical			2	9d. Date s	igned (Monti	h, Day, Year)
	<b>5.≱5</b> 8	-	29b. Signature and title of certifier  > Joce Lyne Kouchtchou, mb  29c. License number  3006376	68		Ma	ay 9,	2009
	iotl		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
2.	1011		Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Ro	oad,	Rockvi	ille,	Md.	20855
	Sta	ate	cocci, no include i					
П	Regist		31. Date filed (Month, Day, Year)  MAY 11 2009  33. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 23e through 29a per phys. 6891 5/27/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** GARVEY R. WILMOTH 4:29 A 10 2009 /Medical May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Harford Upper Chesapeake Medical Center Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 □ F Director 87 246-16-6313 11/18/1921 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21154 3446 Scarboro Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give 7 / 4 ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married if Yes, Give 7/42-Year or Dates 7/17/12 1 ☐ Yes 2 🔀 No Specify: Completed by Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 7 leatth and Mental Hygiene. m 27 is marked other than " Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Maintenance Mechanic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Manley Wilmoth Vina Thompson ဥ Health and N tem 27 is man 19a. Informant's Name/Relationship (Type. Print) 05/10/2009 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara Isabelle Wilmoth/Wife 3446 Scarboro Road, Street, MD 21154 Baltimore, Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 5/13/2009 Street, Maryland Ascension Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee 22. Name and Address of Facility C. Robert 17314 Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PHEUMONITIS **Physician** ASPIRATION /Medical Due to (or as a consequence of): Examiner 3-5 YEARS DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trail Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🛄 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy The performed? Division of Vital 1 □Yes 2 XNo MINOCH, CONVE To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: XIInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No eral Director: / filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ME D0057619 BOOS, OI HAM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Orive Bel Air, MD 21014 Joshua Rubenfeld, M.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 500 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 2, 2009 **Physician** 11:10A™ Shirley Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 1401 Blair Mill Road #405 Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🛭 F 72 DC 578-56-9411 Director August 6, 1936 Usual Residence of Decedent a or 28a-f show be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Director Maryland | Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Items 23a must k USA 1401 Blair Mill Road #405 20910 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status "natural", or Item Black, White, etc. 1 ☐ Yes 2 ☐ KNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than ampliny or other traumatic event, the Monee. 5+ Educator DC\_Public\_Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Fauntlerov Wayland Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paula Singleton / Friend 1246 Delafield Place, NE, Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 □Cremation 3 □Removal from State 4 Domation 5 Other (Specify) May8,2009 Washington National Suitland, Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 21. Si mature of Funeral Pervice Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final netastar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the death certificate be executed physician and ts the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 No P.O. ed by the detached 9 Unknown The law requires that been signed the should be detected Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 perform certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ∏ Yes 2 ∏ No death. Director: 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after filled in within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the

State Registrar

29b. Signature and title of

30. Name and add

31. Date filed (Month,

Year Dav

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person who completed cause of death (Item 23a) (Type, Print)

Jimmy

32. Registrar's Signature

29c. License number

DC MB 33/09

WASHWERN De

3800 RESERVAIR RUAD, NO

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** а м Debbie Jo Walker May 10. 2009 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3704 Old Baltimore Drive Olney Montgomery If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 21 F Director 213-58-8793 56 June 24, 1952 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Show 10a State 10b. County r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 V No Director Maryland Montgomers Olney the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 3704 Old Baltimore Drive 20832 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygie Technical Information Specialist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental H Elmer Stutzman Sarah Grace Patterson traumatic ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any injury or other trau Bruce Walker/Husband 3704 Old Baltimore Drive, Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 15, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 2009 Silver Spring, Maryland 21. Sign I re of Fu eral Service Licensee Francis J. Collins Funeral Home Inc. Thand L Hales 500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gunshot Wound Head **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed and burial-tra Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.0. the detached 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2X No 1 ☐ Yes 2 🗆 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SN Residence 6 Other (Specify) TX Yes 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Hospital or Attending P 24 hours after death. Funeral Director: After t 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1∐Yes 2⊊No 1:20 a<sup>M</sup> Self-inflicted qunshot 2 Accident May 10, 2000 1:20 a 120 in by the 3★ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 3704 Old Baltimore Drive, Olney, MD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00428 May 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira N. Brecher, MD DME 2101 Medical Park Drive, #304, Silver Spring, MD 20902 32. Registrar's Signature State barks Registrar

For State Registrar	State	of Maryland			t of Healt e <i>of Dea</i>			iene eg. No.	009	1700
1. Decedent's Name (First, Middle, Last)							2. Date of Deat Month	h Day	Year	3. Time of Death
L	ai King	Wong					May	05	2009	7:40 a M
4a. Facilify Name (If not institution, gi	ve street and nu	ımber)	-	4b. City,	Town, or Locati	on of Death		4c. Coun	ty of Death	
Wilson Healthcare					Gaithersbur			Montgomery		
Social Security Number 6.	7. Age (In yrs. la	Months Days			Hours Min. 8. Date of Birth (Month, Day,					
213-06-1145	1 □ M 2 🗷 F	87	Yrs.				December	9, 1921	Repub1	ic of China
Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	ocation					1	0d. Inside City Limits
Tod. State		Too. Oity	, 10411 01 20	ocation						1 □Yes 2 X No
Maryland Montgo	nery			101 7	Gaithe	rsburg		0a. Citízen o	41Mh - 4 C	
10e. Street and Number				10f. Zip			'	og. Cilizen o		,
301 Russell Avenue						377		U.S.A.		
11. Marital Status  12. Was Decedent Ev Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ▼ No.			<li>I.S. 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li>				Rican, etc.)	cify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.		
1 Never Married 2 Married	If Yes, G	ive		1 □Yes 2	No Spe	cify:		Spec	cify:	
3   Widowed 4 □ Divorced	Year or I	Jates:	10- D		1 Ones un adian			16b. Kind of	Duningan/In	Asian
15. Decedent's E (Specify only highest g	aucation rade completed)		(Give		Occupation k done during i	nost of work		TOD. NING OF	Dusiness/IN	uusuy
Elementary/Secondary (0-12)	College (	1-4or 5+)	me.		emaker				Own F	Ноше
17. Father's Name (First, Middle, Las	<i>t</i> )			пош		other's Alam	e (First, Middle, N	Maiden Surn		.OBC
	,				16. 10	Caror S (Va(II)				
Man Tok Wong					Hay Nui Lee  ng Address (Street and Number or Rural Route Number, City or Town, State					. 0-4-)
19a. Informant's Name/Relationship	( lype. Print)			3						
Kit La Lee - Daugh	ter	Te	<u> </u>				hersburg,			
20a. Method of Disposition 1   Burial 2 □ Cremation 3 [	☐ Removal from	C4	ace of Dispo emetery, cre	osition (Name matory or ot	ne of her place)		Date	20c. Location	n - City or Te	own, State
4 □ Donation 5 □ Other (Spec			rge Wasi	hington	Cemeter	y 05/0	9/2009	Adelphi	, Maryl	Land
21. Signature of Euneral Service Lice	ensee		H-	ines-Ri	d Address of Fa naldi Fu w Hampsh	neral H	ome, Inc.	er Sprin	g. Mary	71and 20904
disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to Due to Cold	(or as a consequence of the cons	ence of):	V			neetr nvale	itea.	ce eten	3/16/09
IF FEMALE: 23b. Was decedent pregpent in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of pregna birth 2□ Fetal gnant at time of de nown	death 3	□ Ectopic pi □ Other (sp		6 D	See	25d. [	Date of delivery	Pery Year Year
Part II. Other significant conditions  Cyperter  Rheuman	contributing to	death but not resu	ellting in the L	underlying ca	hage	art I.	100	es 2 No	3 ☐ Prol	he cause of death?  bably 4 Unknow
Anemia	ofch	imi	e de	<u>.</u>	ece		autops perform	med?/	prior to co death? 1 □ Yes	opsy findings availabl ompletion of cause of 2  No
25. Was case referred to medical examiner? 1 → Yes 2 □ No	Hospital: 1	Inpatient 2	EB/Outpatio	ent 3 🗆 DO	Others		th (Check only on	re)	Other (Speci	(fv)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	28a. Date (Mo.	e of Injury ofth, Day, Year)	28b. Time of Injury	of 2	8c. Injury at Work? 1 ☐ Yes	/	28d. Describe ho	ow injury occ	mber or Bus	capy
29a. Certifier 1 Certifying F	Physician: To the	ne best of my know basis of examinationner stated.	wled , dea	th occurred	at the time, da		e, and due to the d	cause(s) and	manner as	As Chney
29b. Signature and title of certifier	<u></u>		de	4	. License numl	oer C	2 2 2 2 2 2 3 3 3 3 4 4 4 4 4 4 4 4 4 4	29d. Date sig	ned (Month,	Day, Year)
30. Name and address of person who	BIRSC	HBARL	1,us	, Print)	20 6A	(RU	enseu.	26, 3	NGIG	Brn7
31. Date filed (Month, Day, Year)		Registrar's Signat	par	N						

State Registrar

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036